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ABSTRACT

Part I of this publication contains a background paper, "The Health and Socioeconomic Situation of Midlife and Older Women in Latin America and the Caribbean" (Sennott-Miller). Part II includes and introduction and the following presentations: "Opening Statement" (Crooks); "Empowering Older Women: An Agenda for the '90s" (de Alvarez); "Occupational Health in Midlife and Older Women in Latin America and the Caribbean" (Paltiel); "Perception and Diagnosis: Two Aspects of Chronic Disease in the Midlife Woman in Uruguay" (Niedworok); "Morbidity and Mortality of Midlife Women in Argentina" (Bianco); "Patterns in Medical Service Use among Midlife and Older Women in Costa Rica" (de Madrigal); "The Health Status of the Puerto Rican Elderly: Public Health Policy Implications" (Aviles, Irizarry); "Medical Care for the Elderly: A Study in Kingston, Jamaica" (Eldemire); "Nutritional Status, Socioeconomic Environment, and Lifestyle of the Elderly in August Town, Kingston, Jamaica" (Mesfin et al.); "Social Policies and Planning for Midlife and Older Women in Latin America: An International Approach" (du Guerny); "Profile of the Mexican Elderly Woman: A Comparative Study" (Bialik); "Social Life among Females Aged 75 and Over in Barbados" (Brathwaite); "Informal Support Systems of Widows over 60 in Puerto Rico" (Sanchez); "Psychosocial Perceptions of the Status of Women over 45 in Colombia" (Dulcey-Ruiz, Segura-Barrios); "Female Sexuality and Aging in Colombia" (Velez); "Problems of Data Collection and Research on Midlife and Older Women" (Ferencic); "Role Changes in the

Midlife Woman 45-60 Years of Age in Colombia" (de Pineda); "Widowhood: The Social and Economic Consequences" (Rawlins); "Changing Gender Hierarchies by Cohort in a Brazilian Sugar Plantation" (Aguiar); "Role Changes in Women at Midlife in Argentina" (de Lattes); "The Invisible Worker: Health Conditions of the Domestic Worker in Colombia" (Leon); "Protection of the Elderly Woman in Costa Rica" (Ramirez); "The Aging Female Population in the Caribbean Area: Some Economic Issues" (Scott); "Women and Old Age: Status of the Elderly Woman in Mexico" (de Lehr); "Biopsychosocial Aspects of the Venezuelan Population 60 Years of Age and Older" (Morazzani); "The Aging Woman in Puerto Rico: Public Policy and Priorities" (Cintron); "Socioeconomic Policies and the Status of the Older Woman in Costa Rica" (Blanco); and "Final Report of the Meeting on Midlife and Older Women" (Bianco). (NLA)

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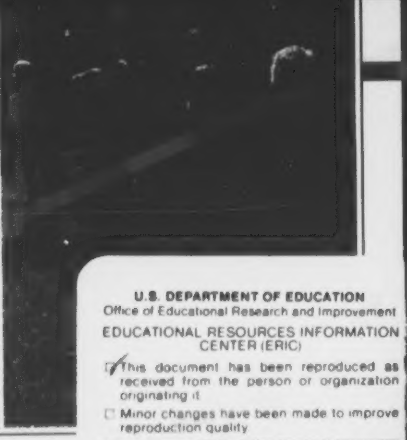

MID-LIFE AND OLDER WOMEN

In Latin America and the Caribbean

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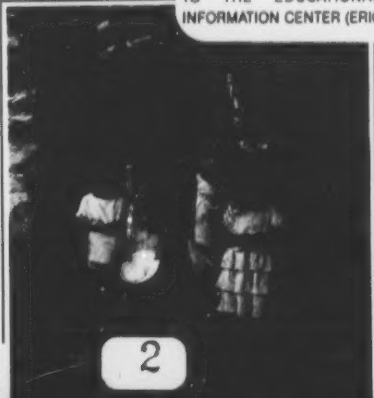

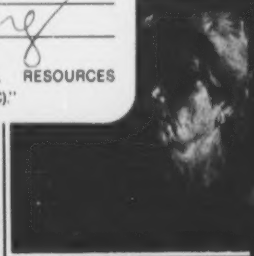

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MIDLIFE AND OLDER
WOMEN

In Latin America and the Caribbean

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Washington, D.C. 20049

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PREFACE

The importance of women's roles in society—including their roles in development—has not been fully recognized until fairly recently. As a result, many opportunities to benefit from women's contributions have sadly passed us by. By the same token, women's particular conditions and problems, and the specific challenges they pose to the health services also have been largely bypassed by research and policy considerations. This publication represents a significant step toward redressing this situation.

First, this publication constitutes a landmark because it represents a joint venture between two organizations—the American Association of Retired Persons (AARP) and the Pan American Health Organization. In fact, this copublication is the product of a close and fruitful collaboration between these two organizations, who joined forces to collect information about midlife and older women in Latin America and the Caribbean and to elicit recommendations that could serve in the future planning of programs and policies of assistance and support for them.

At least as important, this publication is also significant because it focuses not only on women, but on a group which has never before been studied in the Region—midlife and older women. These researchers examine the health and socioeconomic status of this group of women in terms of their physical and social well-being and, perhaps more importantly, in terms of the quality and equality of their lives. Moreover, these scholars from throughout the Region have gone beyond a mere outline of the current status of midlife and older women in Latin America and the Caribbean. They offer recommendations that might help solve at least some of this growing group's problems.

If women's health problems are to be properly addressed and solved in Latin America and the Caribbean, their status must be viewed in the context of the Region's overall social and economic conditions. The latest scientific and technological advances may have given us the tools to solve a myriad of specific disease problems, however, unless health is conceived of as something more than health care and health services and systems, these solutions can only be partial ones.

Furthermore, the responsibility for pursuing women's health and welfare—as with any vulnerable group in the population—must be borne by all elements of society. Nongovernmental associations; special-interest groups, especially women's groups; community associations; families; even individuals must actively participate. Our governments, if they act alone, can only hope for incomplete answers.

Finally, perhaps the role that so many Latin American and Caribbean women at midlife and older play within their families and within society can serve as our example and our guide. Steered by this we can pursue solutions that are less "medicalized," more humanitarian, and more caring.

Our Region is living through "the best of times and the worst of times," to borrow a phrase from Charles Dickens. These are the worst of times because we know that serious problems still loom ahead for us and we also know that we are guilty of squandering our human resources. But these are also the best of times because, in the midst of our crises and our conflicts, we are forced to seek new avenues for cooperation and new opportunities for progress.

This publication is one of these innovative inroads. On the one hand, it shows what can be gained when organizations pool resources and work as one toward a shared goal. On the other, and no less important, it testifies to the invaluable contribution that researchers can make. The contributors to this work, by courageously tackling a new subject, gathering new information, or analyzing old information in new ways have produced a collection as unique as the topic they treat and one that will serve as a resource for other scholars, students, researchers, policy-makers, and social advocates for many years to come.

A full recognition of women's particular health and socioeconomic problems is long overdue. The time, too, has come to acknowledge the important contributions that women have made and continue to make toward holding together the fabric of our families and of society—especially those midlife and older women who represent a storehouse of knowledge, wisdom, and survival. We hope that this publication becomes only one of many efforts to make women full partners in society and in the development process.

Carlyle Guerra de Macedo
Director

INTRODUCTION

This copublication is the result of a 1987 technical cooperation agreement between the American Association of Retired Persons (AARP) and the Pan American Health Organization (PAHO). This agreement was designed to highlight the situation of midlife and older women in Latin America and the Caribbean, a population group which, to date, has received relatively little attention from researchers and policy-makers.

Initial impetus for the project came from AARP's Women's Initiative, under the direction of Elizabeth K. Mullen, and from AARP's International Activities Office, headed by Charlotte Nusberg. At PAHO, the objectives of the project were enthusiastically embraced and supported from the outset by Dr. Helena Restrepo, Program Coordinator for Health of Adults, and by Dr. Elías Anzola Pérez, Regional Advisor, Health Care of the Elderly. Without their support and guidance this project would not have been possible. Irene Hoskins of AARP's International Activities Office provided overall planning and coordination for the joint project.

The project was conducted in two stages. The first consisted of the preparation of an extensive background report based on an exhaustive review of available statistical data and information from published and unpublished sources. Dr. Lee Sennott-Miller completed this background report during a leave of absence from her research responsibilities at the University of Arizona. Dr. Sennott-Miller's report constitutes the first part of this publication.

The second stage of the project was the organization and convening of the first "Consulting Group Meeting on Midlife and Older Women in Latin America and the Caribbean: Current Research and Policy Implications." The papers presented at the meeting, as well as the summary of discussions and recommendations prepared by Dr. Mabel Bianco of Argentina's Ministry of Health and Social Action, constitute the second part of the publication.

This meeting, held October 18-20, 1988, at PAHO headquarters in Washington, D.C., was cosponsored by the United Nations Center for Social Development and Humanitarian Affairs (UNCSDHA) and the United Nations International Training and Research Institute for the Advancement of Women (INSTRAW), as well as by AARP and PAHO. Lee Sennott-Miller provided invaluable assistance in the formulation of the technical agenda and planning of this meeting. Special recognition is due to the speakers and participants of this event, which marked a first step in the effort to increase public awareness regarding the health, psychosocial, and economic situation of midlife and older women in the Latin American and Caribbean Region.

Part I

BACKGROUND REPORT

THE HEALTH AND SOCIOECONOMIC SITUATION OF MIDLIFE AND OLDER WOMEN IN LATIN AMERICA AND THE CARIBBEAN

Lee Sennott-Miller[1]

INTRODUCTION

Little is known about the population segment composed of women at midlife (40–59) and older (60 and over) in Latin America and the Caribbean.

Because the general population of the Region is relatively young, up to now little attention has been paid to women at midlife and older in either research or service activities—only recently have census statistics begun to be disaggregated by sex and age, and services for women continue to be geared more toward problems of maternity than toward those of chronic illness. And yet, although their percentage within the total population is relatively small (between 9% and 20%), the actual number of women aged 40 and older is large and growing. In Brazil alone, there were an estimated 4 million women over 60 in 1980.

Furthermore, the findings suggest that women at midlife and older play a key role in both economic development and in social and family stability in the Region—far more significant than what would be anticipated by their numbers. This is so true that, if their productive resources and caregiving roles were suddenly withdrawn, the effects on the Region's economy would be devastating.

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[1] Research Assistant Professor, University of Arizona; Consultant, American Association of Retired Persons and the Pan American Health Organization.

Despite their significant contributions, these women remain undervalued. They are survivors in a patriarchal system so pervasive that they lack control over the most basic elements of their lives: the distribution of their time; the use of their bodies; the products of their labor; and the decisions that affect their daily existence (Gallin, 1985). They have been inadequately fed, often since childhood, so that many live their lives chronically malnourished. They are expected to bear children and provide the basic domestic labor necessary for maintenance of the family. In addition, they are expected to contribute to the family income with work in the formal or informal sector.

In most cases, particularly in the older age groups, women's education has been so limited that they lack basic literacy and numeracy skills—a condition that keeps them relegated to the lowest status and lowest paying jobs. Yet, since the number of female-headed households increases with age, their income contribution eventually may become the only one sustaining the family. Clearly, women at midlife and older can no longer be ignored or dismissed.

According to Gallin (1985), those who propose to change the repressive system under which women live in developing countries—not only in Latin America, but throughout the world—identify two critical elements. First, power relationships and sex roles must not be regarded as immutable or "natural," as many women in the current study termed them. Second, since informal groups constitute a fundamental basis for association among women, these should become the foundations on which organizations controlled by women should be built. We feel that a third element also should be considered—respected women, at or approaching midlife, should be encouraged to provide leadership, even though this might add some burden to their time and responsibilities.

This study was undertaken in an effort to provide background information that could be used in planning and encouraging more research and programs for women in these life stages.

GENERAL DESCRIPTION OF THE REGION

Perhaps a good way to begin this study is to present an overview of the Region and its population characteristics.

Latin America and the Caribbean encompass such diversity that those who study it have divided the area in a number of ways, in an effort to group countries according to salient similarities. Two methods are currently popular. One, based on climate and geography, groups countries into those in Central America, the Caribbean, Temperate South America, and Tropical South America (UN, 1985b; PAHO, 1985a.) A more recent approach, and the one used in this section, also considers sheer size by treating Mexico and Brazil as subregions, and relies on a finer geopolitical division that separates Temperate and Tropical South America into the Southern Cone and the Andean Area. This division also distinguishes between the Latin and the English-speaking Caribbean, separating them on the basis of language and different historical processes of colonization resulting in different cultural characteristics.

Subregional Characteristics

The countries that comprise each of the subregions to be discussed in this report are listed in Table 1; however, it should be kept in mind that, even within these subregions, some countries differ from others in their category on major points.

Paraguay, for instance, is much less industrialized than the other countries of the Southern Cone, but because of its geographic location and ethnic composition (many persons of Northern European extraction), it is included in this subregion. Then, within the Andean Area, Bolivia and Ecuador are less developed and considerably more rural than the other countries in this category. Brazil's north and northeastern regions bear little resemblance to the more urbanized southern areas, with life expectancies of persons in the northern areas some 12 years shorter than those of residents of the southern part of the country. In the north, also, generally preventable infectious and parasitic diseases still account for large percentages of mortality (PAHO, 1986a, p. 56).

In Central America, too, a couple of countries stand out: Costa Rica because of its historically stable democracy and Panama because of its large enclave of U.S. citizens currently managing the Panama Canal Zone. Mexico, which is often combined with the Central American countries in other classifications, may be the most diverse country in the entire Region: it contains the largest concentration of Indian groups, and at the same time it boasts the megalopolis, Mexico City, making it one of the most urbanized subregions. Collective farms, called *ejidos,* make its rural land-use patterns different from other countries in the Region. It also has a culturally distinct border area with the United States which supports a new industrial phenomenon, the *maquiladores,* or cross-national industries.

While the English-speaking Caribbean embraces a fairly homogeneous group of small islands, the Latin Caribbean consists of four vastly differ-

Table 1. Latin American and Caribbean countries and subregions.

Latin America

- Andean Area
  - Bolivia
  - Colombia
  - Ecuador
  - Peru
  - Venezuela
- Southern Cone
  - Argentina
  - Chile
  - Paraguay
  - Uruguay
- Brazil
- Central America
  - Belize
  - Costa Rica
  - El Salvador
  - Guatemala
  - Honduras
  - Nicaragua
  - Panama
- Mexico
- Latin Caribbean
  - Cuba
  - Dominican Republic
  - Haiti
  - Puerto Rico

Caribbean

- Antigua
- Bahamas
- Barbados
- Cayman Islands
- Dominica
- French Guiana
- Guadeloupe
- Grenada
- Guyana
- Jamaica
- Martinique
- Montserrat
- Netherlands Antilles
- Saint Lucia
- St. Kitts and Nevis, Anguilla
- St. Vincent and the Grenadines
- Suriname
- Trinidad and Tobago
- Turks and Caicos Islands
- Virgin Islands (UK)
- Virgin Islands (US)

Source: Pan American Health Organization, 1986a, p. 11.

ent countries. Haiti stands out because of its use of French as the national language and because of its extreme poverty. Cuba's modernization efforts undertaken by the government after the revolution make it demographically more similar to a country in the Southern Cone. Puerto Rico as a commonwealth is a complex blend of western industrial and developing Latin American characteristics, while the Dominican Republic more closely resembles its Latin than its Caribbean neighbors. Thus, even when efforts are made to aggregate information about Latin America and the Caribbean in a manner that reflects similarities among countries, diversity persists. It should be kept in mind that fairly major differences may be masked when the Region is discussed as a whole, or even by subregions. However, the alternative of not aggregating the information produces a situation in which overall patterns would not emerge.

Population Distribution and Growth

Although the Region's countries generally are considered "young" by most standards—nearly half the population is between 15 and 49 years old and approximately 40% is under 15—some countries, particularly in the Caribbean and the Southern Cone, have relatively large percentages of persons over 60 (Chaney, 1984, p. 4). In the Caribbean, for instance, Cuba, Jamaica, and Barbados in 1980 had populations in which more than 10% was over 60 years old (Chaney, 1984; Eldemire, 1988). By 2025, all Caribbean countries except Haiti will have exceeded this level and, in five of these, the over-60 group will rise to 20% or more. The picture is similar in Mexico, Brazil, the Southern Cone, and parts of Central America and the Andean Area (PAHO, 1985b, p. 16).[2]

Also, the growth rate for the population segment over 60 is expected to be considerably higher than that of the general population. Table 2 shows the total population and the over-60 population in the subregions for three time periods, 1980, 2000, and 2025, with associated rates of growth of each.

As the percent change columns in Table 2 indicate, the highest growth rates for the general population are expected to be in Central America, Mexico, and the Andean Area. Only Central America, however, will ex-

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[2] Projections used in this report are from several sources. All use the U.N. Population Division procedures for estimating and adjusting data. Most use previously published projections from such sources as the various volumes of the *Demographic Yearbook*, *World Population Prospects*, and *Demographic Indicators of Countries*—all UN publications. In the case of data prepared especially for this report under contract with INSTRAW, projections were made in the UN data center, CELADE, in Santiago, Chile. In all cases the projections are based on formulas that take into account the major components of population change: fertility, mortality, and migration. Various levels of these variables are assumed, and estimates made on the basis of these assumptions. In most cases the medium variants, a middle ground projection, are the ones that are chosen as they represent the "best guess" of future trends. According to a recent publication of the US Bureau of the Census, *An Aging World* (Torrey, *et al*, 1987):

> The advantage of using the U.N. data set rests in its integrated framework and temporal conformity, which facilitate the comparisons of various national populations at specific points in time: past, present, and future. For the most part, the convergence of national, U.N. and other projections is quite close, at least in the near future. This is especially true for older population groups, which is not surprising insofar as persons who will constitute the elderly in 2005 and 2025 have already been born. Since the elderly population of, say, 2025 have already survived the risks of infant and childhood mortality, their continued survival is subject to adult mortality rates that can be estimated with a high degree of confidence until the very old ages. Because the effect of migration on projected cohorts are in most cases minimal, absolute numbers of elderly persons may, therefore, be considered fairly reliable (p. 71).

Table 2. Estimated population, projected population, and percent change for total population and population aged 60 and over by subregion in Latin America and the Caribbean; 1980, 2000, and 2025. (Population in thousands).

	1980		2000				2025			
	Total	60 and +	Total	% Change 1980-2000 (Total)	60 and +	% Change 1980-2000 (60 and +)	Total	% Change 2000-2025 (Total)	60 and +	% Change 2000-2025 (60 and +)
Latin America	363,704	23,328	565,747	56	40,990	76	865,198	53	93,317	128
Andean	72,630	3,770	120,229	66	7,114	89	195,850	63	18,079	154
Southern Cone	44,232	4,939	57,009	29	7,118	44	70,476	24	11,351	58
Brazil	121,320	7,464	187,404	54	13,995	88	291,252	55	31,816	127
Central America	22,592	1,086	39,779	76	2,235	106	68,640	73	5,889	163
Mexico	69,752	3,590	115,659	66	6,615	84	173,960	50	17,512	165
Latin Caribbean	25,163	1,925	36,219	44	3,061	59	52,845	46	6,613	116
Caribbean	6,758	672	9,003	33	992	48	11,760	31	2,291	131

Source: United Nations, 1985.

ceed 75%; most are much lower, particularly for the period between 2000 and 2025. Elderly population growth rates are much higher, with the exception of the Southern Cone where the population already is relatively old. These increases are expected to reach up to 106% for the 20-year period between 1980 and 2000 and, with the exception of the Southern Cone, will be well over 100% for the 25-year period between 2000 and 2025. Thus, although the percentages of persons over 60 in Latin America will remain relatively small through the rest of this century, rates of increase show that actual numbers of persons in this category are growing rapidly and will soon represent a subgroup that can no longer be ignored.

Components of Population Change

The major factors of change in the size of Latin American and Caribbean populations are fertility and mortality, with fertility being the more important one. Table 3 displays information about these and about birth rates and life expectancy for the different subregions at two time periods—1980–85 and projections to 1995–2000.

Table 3. Estimates and projected crude birth rates, fertility rates, crude death rates, and life expectancy at birth in Latin America and Subregions for 1980–85 and 1995–2000.

	Crude birth rate (per 1000)		Fertility rate[a] (children per woman)		Crude death rate (per 1000)		Life expectancy at birth (years)	
Region[b]	1980–2000	1995–2000	1980–1985	1995–2000	1980–1985	1995–2000	1980–1985	1995–2000
Latin America	32.2	27.1	3.8	3.5	8.2	6.8	64.1	68.1
Andean	38.3	33.5	5.0	3.5	8.9	6.9	62.6	66.9
Southern Cone	22.7	19.4	3.1	2.9	8.4	8.4	68.4	70.9
Brazil	31.4	26.9	3.8	3.5	8.4	7.2	63.5	67.4
Central America	39.3	33.9	5.8	4.5	8.7	5.9	62.8	69.6
Mexico	36.2	27.3	4.6	3.0	6.9	5.3	66.0	70.1
Latin Caribbean	27.8	22.5	3.4	2.5	7.2	6.6	68.0	71.2
Caribbean	26.3	19.4	2.9	2.2	6.4	6.4	70.4	72.6

Source: Nations, 1985, p. 185, for birth and death rates and life expectancy, and Pan American Health Organization, 1986a, p. 13, for fertility ratios.

[a] Fertility rate is the total fertility rate: the total number of children a woman would have on the average at the end of her child-bearing years assuming exposure to age-specific fertility rates and no mortality.

[b] Entries are median values for the countries making up the region and subregions.

This Table clearly shows that both crude birth rate and fertility rates are expected to drop between 1980 and 2000. Although the pattern is stronger in some subregions than in others, the overall effect is to substantially reduce the crude birth rate in both Latin America and the Caribbean. At the same time, improvements in child survival are expected to reduce the overall crude death rate considerably during this period. Life expectancy at birth will increase as well, although more in response to decreases in infant mortality than to decreases in mortality at later ages (PAHO, 1986a, p. 15; Myers, 1985, p. 173). It is interesting to note that the crude death rate is not projected to decrease in the Southern Cone or in the English-speaking Caribbean, areas where a large and growing elderly population already exists.

Rural-Urban Population Distribution and Change

Another important factor that affects population age distribution and structure in Latin America is rural to urban migration. As has much of the developing world, most Latin American subregions have experienced rapid urbanization over the last 30 years, except for the English-speaking Caribbean where the pace is slower. Unlike many other developing areas, however, Latin America also has had a tradition of urban living that predates even the Spanish colonization of the continent (Hardoy, cited in Chaney, 1984). Thus, in addition to an accelerated migration to urban areas that began in the 1950s, there is a high rate of natural population increase in the cities as well. As Chaney points out (1984, p. 15), one process feeds the other—migration brings more women in their reproductive years into the urban areas where they continue to produce more children, thereby increasing the urban population.

In general, older populations in the world's less developed regions are predominately rural and projected to remain so through the end of the century. UN data sources indicate that for less developed regions, the 60-and-over population percentage in urban areas for both men and women was 29% in 1980 and is projected to increase to 41% by the year 2000. This fact has been used to calm fears of potential problems the elderly face as a result of their geographic distribution. A comment in the UN document, *World Aging Situation*, is illustrative.

> This suggests that the problems of isolated elderly women in urban areas and of high concentrations of very elderly farmers in rural areas may not be as acute in developing Regions (UN, 1985a, p. 34).

However, Latin America provides a stark contrast to the overall picture and belies these reassuring words. Latin America is the most highly urbanized of all the developing regions of the world, with an estimated 65% of its population residing in urban areas. Table 4 demonstrates the growth of the urban population by subregions from earlier censuses conducted between 1950 and 1960 through 1980, and projected to the year 2000. Lacking major urban areas, the small Caribbean Basin islands are clearly an exception to the trend toward ever greater urbanization. The Southern Cone, which was already highly urban in the 1950s and 1960s, is projected to have all but 15% of its population in cities by the end of the century. Brazil, Mexico, and the Andean Area will not be far behind. Central America, as the Caribbean, will retain more of its rural character. By far the largest urban increase will occur in Brazil. The rural-urban distributions and sex ratios for the elderly population are presented by subregions in Table 5. Only in Central America does the rural population exceed the urban for persons over 60, and this is projected to reverse by the year 2000. In all other major subregions, at least 60% of the population over 60 years of age lives in urban areas.

Also, sex ratios in the 60 and older population overall and in every subregion indicate that urban areas are clearly the domain of older women, whereas older men predominate in the rural areas. This pattern is expected to continue. Even given the advantage in female life expectancy, a recent study of Mexican data found sex ratios of 104 males per 100 females in rural areas for both the 65–74 and 75–84 age groups, indicating that elderly men predominate (Ham-Chande, 1986, cited in Kinsella, 1988). Thus, it would be a mistake in the case of Latin America and the

Table 4. Percent urban population in Latin America and subregions, 1960s, 1980, and 2000.

	1960s	1980	2000
Latin America	48.2	65.7	77.1
Andean	51.8	64.9	75.9
Southern Cone	61.4	79.5	85.6
Brazil	46.3	67.5	82.7
Central America	35.4	42.0	52.0
Mexico	50.6	66.4	77.4
Latin Caribbean	43.7	53.5	64.6
Caribbean	—[a]	17.2	24.5

Source: 1960s data: UN, 1979; data for 1980 and 2000 are from PAHO, 1986a, p. 18.

[a] Information for English-speaking Caribbean was not available for this period. These data are not strictly comparable with the other two periods.

Table 5. Estimated and projected urban-rural distribution, and sex ratio (men per 100 women) for the population 60 years and older; 1980 and 2000 (population in thousands).

	1980								2000							
	Urban population				Rural population				Urban population				Rural population			
	Men	Women	Both	Sex ratio[a]	Men	Women	Both	Sex ratio[a]	Men	Women	Both	Sex ratio[a]	Men	Women	Both	Sex ratio[a]
Latin America	9,727	11,942	21,668	81	5,496	4,961	10,457	111	19,450	23,770	43,220	82	6,992	6,299	13,290	111
Andean	1,547	1,924	3,471	80	1,099	1,064	2,163	103	3,496	4,155	7,652	84	1,241	1,190	2,431	104
Southern Cone	2,477	3,137	5,614	79	615	615	1,126	120	3,664	4,838	8,502	76	656	558	1,215	118
Brazil	3,292	3,892	7,184	84	1,937	1,937	3,640	114	7,175	8,387	15,563	86	2,339	2,047	4,386	114
Central Amer.	322	424	746	76	442	442	836	112	778	997	1,774	78	736	641	1,377	115
Mexico	1,486	1,891	3,378	79	906	906	1,780	104	3,220	4,091	7,311	79	1,195	1,141	2,336	105
Latin Carib.	642	727	1,369	88	498	498	911	120	1,116	1,301	2,418	86	570	570	1,073	113

Percent of total population

	1980						2000					
	Urban population			Rural population			Urban population			Rural population		
	Men	Women	Both	Men	Women	Both	Men	Women	Both	Men	Women	Both
Latin America	30	37	67	17	15	33	34	42	76	12	11	24
Andean	28	34	62	20	19	38	35	41	76	12	12	24
Southern Cone	37	47	83	9	8	17	38	50	88	7	6	12
Brazil	30	36	66	18	16	34	36	42	78	12	10	22
Central Amer.	20	27	47	28	25	53	25	32	56	23	20	44
Mexico	29	37	66	18	17	34	33	42	76	12	12	24
Latin Carib.	28	32	60	22	18	40	32	37	69	16	14	24

Source: UN data prepared by INSTRAW.
[a]Men per 100 women.

Caribbean to be sanguine about the elderly's problems which stem from their rural-urban distribution.

Kinsella summarizes the latest thinking regarding the effects of this distribution throughout the developing world:

> The consensus to date is that rapid urbanization in developing countries has had a more deleterious effect on urban as opposed to rural elderly. The growth of urban economies has increased employment possibilities outside the home for women as well as men. However, there is little relation between urbanization and labor force participation at older ages. Rather, the new economic opportunities have mainly accrued to younger workers. Traditional family care givers often enter and remain in the work force, thereby complicating the provision of care for elderly family members. Unless the latter have a work history of government service, they are unlikely to qualify for pension support, and are more likely than other population segments to require some form of economic assistance. At the same time, urban housing may be poorly suited to traditional extended family arrangements, thereby forcing a choice between limited privacy and alternative means of shelter. (Kinsella, 1988, p. 12).

Given the highly urban character of the Latin American Region and the preponderance of women in urban settings, if this analysis is accurate, women, once again, suffer most.

THE NEED FOR A STUDY OF OLDER WOMEN

Kinsella's persuasive argument notwithstanding, a cursory look at the situation of women in Latin America and the Caribbean today would lead many persons to conclude—as have most national and international agencies—that both concern and funding should focus on women of childbearing age. In all of the Region's countries, women 15 to 49 represent nearly half of the female population (Chaney, 1984, p. 4). In addition, given that it is these same women who bear the burden of reproduction in the family, it is easy to understand why they, rather than older women, have been given priority.

A closer look, however, reveals some rather sobering facts. As mentioned earlier, demographers agree that population aging is mainly a function of the decrease in fertility and mortality (Siegel, 1981; Myers, 1985). High fertility levels coupled with high mortality levels produce slow population growth and a younger age structure. Many children are born, but many also die and life expectancy is low at birth and at later stages (UN, 1985a, p.183). When infant mortality rate is slowed by such things as the child survival efforts described before, the population becomes even more youthful and a "population explosion" results (UN, 1985a). This has been the situation in all but a few of the countries of Latin America and the Caribbean for several decades, as infant mortality has been steadily reduced while birth rates have remained high or have decreased more slowly (PAHO, 1985a, p. 9; Chaney, 1984, p. 128).

Paradoxically, it is this type of population structure that will produce the largest increase in the absolute numbers of older persons over the next 50 years, as cohorts of healthy children survive to old age. Thus, particularly in certain subregions of Latin America and the Caribbean, such as Central America and Tropical South America, where fertility is projected to remain high until the end of the century, the size of the elderly population will jump by factors of four to six between 1980 and 2025, versus factors of only 3.4 for the Caribbean and 2.2 for countries such as Argentina, Uruguay, and Chile (UN, 1985a, p. 183). For example, between 1985 and 2025, the population over 65 years of age in Guatemala is expected to increase by 357%, from about 234,000 to 1,070,000 (Torrey, Kinsella, and Taeuber, 1987, p. 6). Ironically, it is the countries least prepared or equipped to handle the social security and specialized health care needs of a large elderly population that will have the largest increases.

Given that women in Latin America and the Caribbean, as in all other areas of the world, are projected to continue to have an advantage in life expectancy over men, the aging population will continue to be predominately female. In Latin America and the Caribbean, current average life expectancy at birth for men is 62.1 and for women, 66.3. By the year 2025, this is expected to increase to 66.8 for men and 71.4 for women (PAHO, 1985a, p. 15). Survivors to age 60 can now expect to live another 15 years if they are men and 17 years if they are women (UN, 1979). This means that the number of "oldest old"—those 75 to 80 and older—will increase tremendously in the years to come. Therefore, although men will live longer, demographers predict that this trend of differential life expectancy between men and women will continue well into the twenty-first century. With elderly women outnumbering elderly men, the social, economic, and health problems of the aging population will be largely the problems of women (WHO Special Program for Research on Aging, 1988).

What is the Magnitude of the Problem?

If one looks only at the proportion of the population considered elderly (60 and over using the definition employed in UN publications since

1980), it is hard to become alarmed at the 1980 overall level of 6.4% in Latin America and the Caribbean, even when this is expected to rise to 7.2% by 2000 and to nearly the current level in the United States, 10.8%, in 2025. Yet in a country such as Brazil, with a 1980 population estimated at somewhat over 122 million and a proportion of persons 60 and over of 6.1%, the actual number of elderly people involved translates to a staggering nearly 7.5 million. Approximately 3.3% of these—over 4 million persons—are women. This would be equivalent to having the entire 1980 population of Paraguay or the state of Washington be nothing but women over the age of 60!

If women at midlife are added to this figure, the proportion of midlife and older women combined (defined as 40 years and older) never falls below 9% among the countries included in this study; in 10 countries it reaches 10% or more. The highest proportion, 19.9%, is in Uruguay, representing a group of nearly 600,000 women. The same age range in Brazil comprises a group of over 12 million women. Even in a country such as Haiti, with a female life expectancy of only 52 years, nearly 600,000 women were over the age of 40 in 1980.

It is important to remember that, with the exception of census data, the information on which this report is based comes almost exclusively from studies of women in the "popular sector." These are women whose social, educational, and economic resources are, at best, marginal for maintaining a comfortable quality of life. It is not possible from the available data to determine exactly how many women at midlife and older fall into this category; however, information about education, employment, family size, and other factors to be discussed later suggests that these women are in the majority in most countries of the Region.

To fully understand the magnitude of the problem, however, requires more than numbers; a view of what life might be like for women at midlife and older if their needs are not acknowledged and understood soon is also needed. For the large majority of women in the popular sector, the picture is not pretty.

Her cultural values and the values to which she herself subscribes, render a woman, by definition, less useful as she ages, since she can no longer bear children. In rural areas she may have been abandoned by both husband and children and she may be required to provide and care for her grandchildren and elderly parents as well (Youssef and Hetler, 1984). In urban areas, she may find herself in an environment in which she is generally less prepared educationally and socially than her younger counterparts to obtain salaried or paid employment. If employed, she may suddenly find herself out of a job, displaced by a younger worker. Widowhood is a probability. Without stable employment in her or her husband's background she will be unlikely to receive government old-age assistance. She will find herself increasingly unable to remain independent as she ages, and will be forced to rely on extended family, neighbors, and other resources for support. In both rural and urban settings, years of childbearing and sacrificing her own nutrition for that of her family may have caused chronic anemia and left her irritable, lacking energy, and subject to frequent infections. Health services that she will need will be designed with younger persons in mind, with programs geared more toward maternity than menopause. Anxiety and depression may occur frequently, and her sense of worth to herself and to society is often a casualty of her powerless situation.

This is a worst-case scenario, of course. Women have been aging successfully in Latin America, as elsewhere, for many centuries. However, the disadvantages that they suffer in the process, coupled with their rapidly increasing numbers, make it imperative that they no longer be ignored. It is time to assess both their strengths, so they can be recognized as resources, and their needs, so they do not overburden the already strained budgets of the developing countries of the Latin American Region.

Information about Older Women

Women everywhere share many experiences: being socialized as women, being educated in the ways of the culture, learning and doing "women's work," marriage, pregnancy and birth, assuming responsibility for mothering, fulfilling certain roles within the family, and, frequently, widowhood. The experience may differ depending on cultural, political, class, and geographic factors; however, because of the commonality of certain experiences, it is possible to compare women on the basis of major categories of information such as education, employment, marital status, numbers of children, health status, etc.

This comparison is facilitated when cultural, societal, and geographic influences do not differ greatly. Unfortunately, that is not the case among women in Latin America and the Caribbean. There are vast differences in the Region in several factors that would influence the ways in which universal aspects of womanhood would be experienced. Geography varies from landlocked mountainous areas to tiny islands, from arid desert terrain to impenetrable tropical jungle. Four major languages and countless indigenous dialects are spoken. All major racial groups are represented, and ethnic differences are numerous. Some countries such as Mexico, Guatemala, Peru, Bolivia, and Ecuador have large indigenous populations which are not even accounted for in the censuses (Parada, 1988).

General levels of development also differ widely, sometimes promoting and sometimes limiting opportunities for both men and women. Highly urbanized countries offer different challenges than highly rural ones. Internal and international migration patterns are not uniform; political unrest and conflict, endemic in the Region, assume extremely violent and disruptive forms in some countries.

Yet, one thing remains clear and relatively consistent throughout: women at midlife and older are largely invisible in terms of the information about them in published and unpublished documents; their specific inclusion in policies, plans, and programs of social welfare; and their representation in the political process. Although pockets of interest in their welfare exist, the major focus remains on youth. Thus, the information in this report is often speculative and based on likely scenarios rather than documented facts.

Important Influences

There are many ways in which the experiences of older women differ from those of both younger women and the general population. The effects of rapid social change over the last 25 to 30 years have had a differential impact on older women in terms of their education, employment, and culturally prescribed roles, as well as in terms of their physical and mental health. Two factors stand out as having major importance in how the older woman fares in life and how she responds to her situation—age and rural or urban residence.

Although it is difficult to sort out the effects of life stage or experiences, women now at midlife, defined here as 40 to 59, seem to have caught the wave of modernization to a greater extent than those who were somewhat older when it began. They differ from their older counterparts in terms of their marital status, their level of education, the kind and quantity of employment in which they are engaged both in and outside the home, and their physical and mental health status. These and other aspects will be examined in depth later in this paper. Particularly at the lower end of the age range, women reap the benefits (in terms of fuller employment and eligibility for pensions) and risk the hazards (in terms of work and environmental stresses). They are also subject to continuing fertility and many will have young children of their own to care for, as well as grandchildren and, quite likely, their own parents.

Older women face somewhat different burdens in relation to fixed and inadequate income, increasing chronic illness and functional disability, increasing dependence on others, and requirements for scarce medical services.

The differences produced by urban or rural residence also are profound. Each location has advantages and disadvantages. We will see in the sections that follow that rural women at all ages are at a disadvantage in terms of poorer education, earlier marriage with more frequent childbearing, poorer nourishment, more physically demanding work, and little access to health services.

Rural women's isolation is also considered an important factor. Men often migrate to the cities or to other areas for long periods and sometimes permanently, leaving women abandoned. Both Youssef and Hetler (1984) and Leon de Leal (1979) relate that, although younger women can migrate to urban settings, this alternative is not usually open to older married women with children. Middle-aged rural women often head very large households as they become grandmothers living with married children and grandchildren (Youssef and Hetler, 1984, p. 48). Rural women's economic status also varies by age. Among those over 50, as age increases, income decreases in rural households headed by women, while just the reverse is true for men (Youssef and Hetler, 1984, p. 49).

Perhaps the greatest disadvantage of rural life for women, however, has to do with the weight of a culture in which they are totally subordinated to men. These cultural patterns are stronger in rural areas. The concept of *machismo* is developed more thoroughly in the section on "Health Status." It is sufficient to say that the culture devalues and denigrates everything relating to women. Although this is true as well in urban areas, gender differences are much more clear-cut in the countryside. Although abandonment by her partner may increase a woman's independence and power in some ways, it also deprives her of any financial support and forces her to rely even more on extended family, with the attendant culturally prescribed duties and responsibilities.

In a discussion of the socialization of rural children, Muñoz de Vera (1982) states that women are trained to be housewives, and men to be "productive." In reality women participate, often at a decision-making level, in nearly every aspect of agricultural production. Yet viewed from the cultural perspective, the man works and the woman doesn't. In rural areas it is more accurate to say that women have two jobs, while men have only one.

When asked if her life in the countryside was hard, a 53-year-old peasant woman replied:

> It's hard work, especially for the woman, because however hard things are, when the man gets home he is served and can rest, but sometimes the woman has no time to sit or even eat (Campana and Lago, 1984, p. 42).

The urban setting presents a totally different set of challenges for women. Although there are high rates of female-headed households in both rural and urban areas and in both areas this phenomenon increases with age, the problem reaches nearly epidemic proportions among elderly women in urban areas. In Costa Rica, for instance, more than 36% of urban households headed by persons over 60 were headed by women. In the rest of Latin America the same pattern holds true at only slightly lower levels.

Often urban women lack the support of an extended family, having migrated to urban areas as young girls in search of employment. The goal is to find factory work, but it is seldom achieved. More often, the poorly educated rural migrant finds that employment as a domestic servant is her only recourse. Frequently, young women may be sent into domestic service as a means of reducing pressure on a rural family unable to feed a large and growing number of children. One or more daughters, as young as 11 years old, may be sent to the city by arrangement with a real or fictive "aunt" or godparent to the home of a *patrona* who promises to feed, clothe, train, pay, and educate the child in return for her services in the household (Jelin, 1987; Bunster and Chaney, 1985; Young, 1987). Unfortunately, the situation in the home is often not as advertised and treatment of the child is frequently severe. The young girl has no say in the matter and her plight is looked upon by some as a type of slavery (Sindicato de Trabajadoras del Hogar de Cusco, 1982).

When these women start their families, often through a series of temporary sexual unions, they are no longer wanted as domestic servants and must resort to other types of marginal employment to support their children. As women age, it becomes more and more difficult to provide this support, and various strategies, to be discussed later, are used to ensure survival.

It seems clear that for women in the lower classes neither rural nor urban life is easy. Although the problems they face—housing, nutrition, work, childbearing and rearing, and relationships with others—are the same, the context in which they occur is so different that the resulting solutions often bear little resemblance to each other. For this reason, rural and urban residency was chosen as one basic unit of analysis.

Organization of the Report

These two broad categories—life stage and rural or urban residence—are used in this report to frame the discussion of major factors that influence the health and socioeconomic situation of women at midlife and older in the Region. To facilitate reporting and discussion of demographic and socioeconomic differences, each category was further divided into three subcategories. For purposes of comparison, the rural-urban dimension was obtained by grouping countries for which there was generally comparable data into categories of highly urban, mixed, and highly rural on the basis of the urban-rural ratio of women at midlife (40–59).[3]

Countries included in the urban-rural ranking scheme, their placement, and the urban-rural ratio of women 40 to 59, i.e., the number of urban per each rural woman, are listed in Table 6. It should be noted that although countries of the Latin Caribbean are included, comparable data disaggregated by urban-rural residence, age, and sex were not available for the English-speaking Caribbean. A discussion of these countries will be interwoven onto the narrative when data from regional surveys and publications are available.[4]

Because several authors (UN, 1985a; Myers, 1985; Kinsella, 1988) have pointed out that in certain countries where population aging has been occurring for a fairly long time, greater numbers of persons are living well into old age, three age subdivisions also were made. Brazil and Mexico, for example, are projected to have a population of over one million 80-year-olds in 2025 (UN, 1985a, p. 30). It seemed that the differences between the experiences of the oldest old and those at midlife and older might follow certain patterns; thus, the upper age range was divided into older women (60 to 74) and the very old (75 and over). The result of these divisions is a matrix such as the one in Figure 1, within which the major characteristics affecting older women's lives will be examined.

This framework is better than other ways of looking at the information, in that it is derived from and directly addresses the problem of midlife and older women in the Region. Unfortunately, however, the framework was not useable with all of the information. In many cases, age data were not disaggregated according to these theoretical divisions and the upper age ranges had to be combined with lower ones because information was available only for 60 or 65 and over. Problems of definition about what constitutes rural and urban sometimes also made the

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[3] The decision to rank countries on the basis of the population of women aged 40–59 years old as opposed to either of the other life stages, or the entire group of women over 40, was made to avoid the unknown effects of bias that might be introduced by higher mortality in the other age ranges. The rankings differed slightly when the other two age groups were used to order the countries; however, they fell into the same general categories of highly urban, mixed, and highly rural.

[4] These rankings correspond very closely to urban-rural rankings of countries based on data from the general population (PAHO, 1986a, p. 194), indicating that the countries can be discussed as "urban," "rural," or "mixed" in a general sense, not just as this pertains to the proportion of midlife women in their populations.

Table 6. Country placement in ranking scheme, and number of urban women aged 40–59 per one rural woman aged 40–59.

Country type					
Highly urban		Mixed		Highly rural	
Country	Urban/rural ratio	Country	Urban/rural ratio	Country	Urban/rural ratio
Uruguay	7.3	Puerto Rico	2.6	Ecuador	.9
Argentina	6.6	Brazil	2.5	Paraguay	.8
Chile	4.7	Mexico	2.2	Bolivia	.8
Venezuela	3.3	Colombia	2.2	Guatemala	.7
Cuba	3.1	Peru	1.7	Honduras	.6
		Nicaragua	1.5	Haiti	.3
		Dom. Republic	1.2		
		Panama	1.2		
		Costa Rica	1.1		
		El Salvador	1.1		

Source: UN data prepared by INSTRAW, 1980 projections.

	Country type		
Age cohort	Highly urban	Mixed	Highly rural
40–59	Rate or frequency of characteristic		
60–74			
75 +			

Figure 1. Analytical framework for discussion of major factors.

data noncomparable across countries. In other cases, a combination of actual and projected data or data from separate sources had to be used in order to observe trends. Despite these problems, the use of this analytical model has made it possible to explore a number of demographic factors in a consistent manner. This, in turn, has allowed patterns to emerge. Thus, for instance, the education of a woman currently at midlife in a highly urban setting can be compared and contrasted with that of a very old woman in a highly rural setting. In future research, profiles of these women could also be constructed using this framework to illustrate both common elements and those that differ as a result of life stage and residential location.

POPULATION CHARACTERISTICS OF WOMEN AT MIDLIFE AND OLDER

As mentioned earlier, although women at midlife and older do not represent a substantial proportion of the population in comparison with other segments, numerically they constitute a large and growing group. Table 7 shows the median percentage of total population represented by the three age groups of women by urban or rural residence within the country groupings.[5]

Table 7 shows that not only do the more highly urban countries have a higher median percentage of women at midlife and older in urban areas (11.1), they also have a higher overall total of women at midlife and older (13.4) than mixed (9.4) and rural (9.2) countries. Since the more highly urbanized countries are found in the Southern Cone and since these countries also contain larger numbers of elderly (see Table 6), it makes sense that a higher proportion of the total population should consist of midlife and older women, since women predominate among the urban elderly. Although the total median percentage of women over 40 is nearly the same for the mixed and highly rural countries, their distribution in urban and rural areas is very different. On the average, women over 40 are more likely to be found in urban areas in the mixed countries (5.8%) and in rural areas in the highly rural countries (5.3%).

Of interest also is the change that has taken place and is likely to take place in the percent of midlife and older women in these country groups over time. Table 8 and Figure 2 display this information. The separate effects of migration and mortality are impossible to sort out in this analysis; however, several trends can be observed by examining the urban-rural ratios and the percent change in population at various points in time. Looking first at women at midlife (40–59), the median proportion of the total population that they represent generally increases over time, albeit slowly in the highly rural group. However, the pattern of change shows

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[5] The measure of average percent (or proportion) used in all cases was the median, i.e., the middle point of the distribution. It was used instead of the mean because it is not affected by extreme values.

Table 7. Median percentage of total population by cohort and by urban-rural residence within country types; 1980 projections.

	Country type					
	Highly urban		Mixed		Highly rural	
	Urban	Rural	Urban	Rural	Urban	Rural
40–59	7.1	1.5	4.0	2.6	2.8	3.8
60–75	3.0	.6	1.4	.8	.9	1.2
75+	1.0	.2	.4	.2	.2	.3
Totals	11.1	2.3	5.8	3.6	3.9	5.3
Country type totals	13.4		9.4		9.2	

Source: UN data prepared by INSTRAW, 1980 projections.

an increase in urban areas and a decrease in rural areas. Thus there is a growing proportion and number of urban women in this age group.

The growth rate (percent increase) for women at midlife is highest from 1960 to 1980 in the more urban countries, but projected increases between 1980 and 2000 will be highest in countries in the mixed category. In terms of urban-rural ratios, all three groups of countries show increasingly large ratios for women at this life stage over time, indicating higher urban concentrations. Even in the highly rural countries, the increase in 40–59 year-old women in urban areas is projected at nearly 30% between 1980 and 2000.

As was the case with women at midlife, the percentage of women in the population generally increases over time among the 60–74 year-old women, with some exceptions. Again, median percentages generally increase in urban areas over time and fall in rural areas, although to a lesser extent than in the younger group. Urban-rural ratios rise over time in all three types of countries for older women as well, and projections indicate the percent increase will be even higher than among 40–59 year olds in highly urban and highly rural countries. The overall result for this age group is very much the same as for women at midlife: an increasing proportion of this group within the total population with increasing rates of growth in urban areas.

Finally, median percentages of women in the oldest-old age group also follow similar patterns. Urban concentrations increase and the gap between numbers of urban versus rural women, represented by increasing urban-rural ratios, widens. An important difference, however, is that the proportion of oldest old women in rural areas of all three country types has been, and is expected to remain, remarkably stable over the 40-year period. The interplay of factors such as mortality, changing population structure, and migration help account for this finding. Although it cannot

Table 8. Median percent of women in the total population, urban-rural ratio, and percent change by country grouping and residence for 1960s, 1980, and 2000.

Age		Country type																	
		Highly urban						Mixed						Highly rural					
		Urban			Rural			Urban			Rural			Urban			Rural		
		1960	1980	2000	1960	1980	2000	1960	1980	2000	1960	1980	2000	1960	1980	2000	1960	1980	2000
40–59	% of population	5.6	7.1	9.4	2.2	1.5	1.3	3.2	4.0	6.0	3.4	2.6	2.1	2.4	2.8	3.6	4.1	3.8	3.1
	urban/rural	2.2	4.7	7.8				1.0	1.6	2.7				.6	.7	1.2			
	% change		27	32		−32	−13		25	50		−24	−19		17	29		−7	−18
60–75	% of population	2.5	3.0	4.2	.7	.6	.5	1.1	1.4	1.9	1.0	.8	.7	.8	.9	1.2	1.3	1.2	1.0
	urban/rural	2.6	4.7	7.4				1.2	1.8	2.7				.6	.8	1.2			
	% change		20	40		−14	−17		27	36		−20	−13		13	33		−8	−17
75+	% of population	.6	1.0	1.6	.3	.2	.2	.3	.4	.6	.3	.2	.2	.2	.2	.4	.4	.3	.3
	urban/rural	2.2	5.0	8.0				1.0	2.0	3.0				.5	.6	1.3			
	% change		67	60		−33	0		33	50		−33	0		0	100		−25	0

Source: Data for 1960s are from UN, 1979; Argentina and Bolivia are missing, data for Chile and Dominican Republic not used because they were from the 1950 census. Data for 1980 from INSTRAW projections except for Puerto Rico which was from UN, 1979. Data for 2000 from INSTRAW projections; Puerto Rico missing.

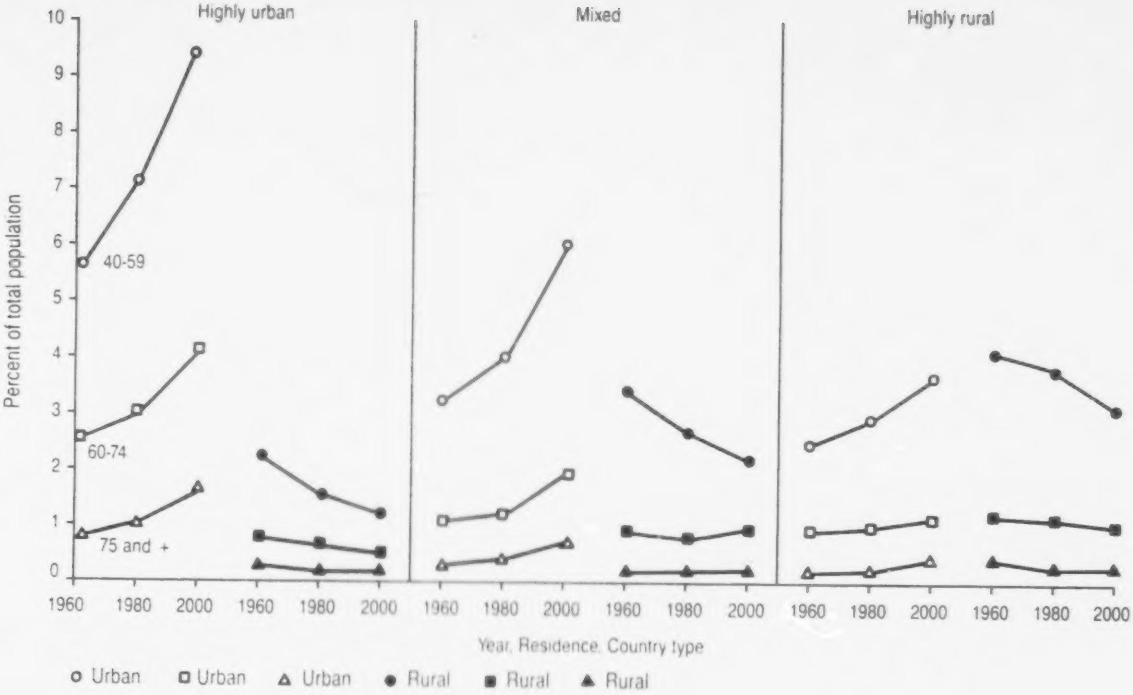

Figure 2. Median percent of total population for women of selected ages.

be tested with the present data, one possible explanation is that at this lifestage, migration to urban areas becomes a less important factor and women simply "age in place" with urban increases caused by longer lived older women who migrated earlier.

Urban and Rural Sex Ratios

To try and determine when migration to the urban areas takes place, sex ratios for selected age cohorts were calculated for three time periods. Data were inadequate among countries in the urban group to calculate averages for the 1960 time period, but the patterns in mixed and rural countries were very stable over time. Table 9 presents median sex ratios (men per hundred women) by urban and rural location within country categories for selected age groups around 1960 in mixed and rural countries and projections for 1980 and 2000 for all three country types.

In rural areas, the dominant pattern shows ratios over 100, indicating that more men than women reside there, and in urban areas they are under 100, indicating more women than men. This begins as early as the 10-14 year age cohort and becomes very clear by the cohort from 15-19. Young women begin migrating to the cities at very early ages.

Differences from 1960 to 1980 were greater than those predicted for 1980 and 2000. The projections call for a leveling off of the trend, with more equal ratios until the 60-74 cohort is reached. Male mortality then begins to take its toll and the pattern described earlier of elderly women in the urban areas and elderly men in the rural areas is seen quite clearly. A disturbing trend toward decreasing sex ratios (fewer males per 100 females) among the oldest old (75+) even in rural areas in urban and mixed country groups according to projections for 2000 will leave even more elderly women widowed and at greater risk and disadvantage in the future.

Several theories have sought to explain these sex ratio differences. In general it is felt that an increasingly mechanized agricultural economy is forcing women out of work in subsistence farming (Duarte, 1988). The takeover of peasant lands with subsequent loss of small landholdings means less land for children to work. Technology more suited to men makes women's labor no longer as necessary in the rural areas and their lack of productivity makes them a drain on family resources. Jobs in domestic service and street selling are relatively plentiful in urban areas and female children are often placed with a *patrona* in the city (Bunster and Chaney, 1985). Those who come to urban areas as young women stay on, and the sex ratios continue to be unbalanced. These theories will be discussed in depth in subsequent sections of this report.

Table 9. Median number of men per 100 women by age, residence, and country type, 1960s, 1980, and 2000.

	Country type															
	Highly urban				Mixed						Highly rural					
	Urban		Rural		Urban			Rural			Urban			Rural		
Age	1980	2000	1980	2000	1960	1980	2000	1960	1980	2000	1960	1980	2000	1960	1980	2000
0–9	104	104	104	104	104	101	102	103	104	104	101	101	103	104	103	102
10–14	100	102	112	111	95	97	100	100	108	108	96	97	99	112	106	107
15–19	98	100	124	121	84	92	95	106	113	114	86	92	95	98	110	113
20–29	96	100	121	123	82	93	97	102	111	112	86	94	94	99	108	108
30–39	97	99	121	125	87	95	95	104	112	112	88	93	98	102	106	105
40–59	93	95	128	131	92	97	89	117	113	115	87	87	89	107	106	107
60–74	81	78	128	129	84	75	81	119	111	117	87	76	80	107	101	104
75 & +	67	59	103	91	63	63	65	106	100	92	61	66	66	93	88	93

Source: Data for 1960s are from UN, 1979; Argentina and Bolivia are missing, data for Chile and Dominican Republic not used because they were from the 1950 census. Data for 1980 and 2000 from INSTRAW projections, except for Puerto Rico which was from UN, 1979. Puerto Rico missing for 1980.

Marital Status

Available information about marital status of women at midlife and older in Latin America and the Caribbean is, for the most part, not disaggregated by rural and urban residence. Table 10 was prepared from national census data for a few countries in each country category. Because most countries do not provide data for the upper age ranges, only two cohorts, 40–59 and 60 and over, are presented. This limits the usefulness of the information for determining the extent of widowhood and for establishing the point at which it becomes a major factor in the aging woman's experience.

Despite these limitations, Table 10 does show that in all countries and in both age groups a larger proportion of rural than urban women are married, and a larger proportion of urban than rural women are widowed. For women at midlife, the percentages of married in both urban and rural settings are remarkably similar across country types. Widowhood in this younger age group seems to be more common in highly rural countries, both in urban and rural settings. Single and separated or divorced categories assume more prominence in mixed-category countries.

In the older age range, widowhood becomes a more relevant problem. In fact, the proportion of those widowed exceeds that of those married in urban areas of the highly urban and highly rural countries, and is nearly

Table 10. Median percent of women in various marital statuses by country type and by urban-rural residence at selected ages.

	Country type					
	Highly urban[a]		Mixed[b]		Highly rural[c]	
Marital status	Urban	Rural	Urban	Rural	Urban	Rural
Age 40–59						
Married	69.8	79.9	65.5	76.7	67.5	78.0
Widowed	10.1	7.8	6.8	6.0	13.6	11.7
Single	11.3	10.0	16.4	9.7	10.0	4.0
Sep/Div	8.8	2.7	11.3	7.6	8.9	6.3
Age 60 & +						
Married	40.7	50.5	37.0	46.2	34.4	45.2
Widowed	43.1	35.0	35.2	33.0	46.4	39.2
Single	14.0	14.9	19.9	13.8	12.1	6.0
Sep/Div	2.2	0.0	7.9	7.0	7.1	9.6

Source: Data prepared by INSTRAW in periods between 1971 and 1980.

[a] Argentina, Chile, & Uruguay.

[b] Costa Rica, Nicaragua, & Panama.

[c] Bolivia, Guatemala, & Honduras.

equal in countries in the mixed group. In rural areas, on the other hand, the percentage of those married exceeds those widowed by nearly 15% in all country types.

High proportions of married women in rural areas, particularly among those in the younger cohort, may reflect the sex ratios. There are simply more men and fewer women in the countryside and remarriage after widowhood may be more likely for younger women. In the older cohort, the higher percentage of married women in rural areas is harder to explain, although some sources (UN, 1985a; Anzola Perez, 1985) have suggested that widowed rural women may move to the cities to be closer to children who migrated previously and to be closer to urban health services.

Fertility

The ability to bear children is a woman's most important asset in any developing country. Apart from the status conferred to a woman with many children, children represent an additional source of family income and potential support in old age when parents may become dependent. Unlike most women in developed countries whose rates of childbearing decline sharply after age 40, many women in developing countries continue to bear children well into their fifth decade. This pattern is particularly true for women in rural areas.

Table 11 shows the median age-specific fertility rate for women in two midlife cohorts within country groups; the numbers represent median number of births per thousand women in the age group. It is clear that the experience of childbirth has not ended for all women in the early part of midlife. In the highly rural countries, in fact, nearly one out of every 10 women 40 to 44 will give birth. Even in the latter half of their fifth decade, nearly 2% of women will give birth in rural countries.

Table 11. Median age-specific fertility rates (live births per 1000 women) in selected midlife cohorts by country type.

	Country type		
Age	Highly urban	Mixed	Highly rural
40–44	20.5	51.4	91.7
45–49	3.4	10.2	17.8

Source: Pan American Health Organization, 1986a; adapted from Table 1-8.

Table 12 displays the median number of live-born children of two age groups by urban or rural residence within country groupings. The data used in this Table were incomplete for the upper age ranges, thus only two groups are presented. Nonetheless, the pattern, particularly between rural and urban settings within country groups, is clear. Even in the highly urban countries, rural women have more children than urban women (4.3 and 4.7 versus 2.6 and 2.8). The median number increases to 6 or higher in rural areas of mixed and rural countries.

Having many children, however, is a mixed blessing. Before they can contribute to the family, they represent a drain, both physically and financially, on family resources. The physical toll on a woman who bears many children—particularly in rapid succession—is only now beginning to be recognized in developing countries (Moreno-Navarro, 1987). In many of the Region's areas, there are high rates of anemia among pregnant women, a problem that seems to exist in both rural and urban settings and that cuts across socioeconomic levels (Royston, 1982). If women at midlife are still having children, they are still at risk. The effects of chronic iron-deficiency anemia on older women are also of concern; these will be discussed in depth in the section on "Health Status."

In addition to rural or urban residence, there are many other factors unrealted to fertility that affect the actual number of children born to women during their reproductive years. Table 13 illustrates the dramatic impact of education. Among women in the 40 to 44 and 45 to 49 year age groups, as educational level increases the number of children decreases dramatically. Although the Table does not reach beyond early midlife, it will be shown in the following section that the older the woman, the less formal education she is likely to have acquired. Thus, one could speculate that a similar fertility pattern would be found among older women as well.

Another deeply influencing factor appears to be economic activity. Table 14 categorizes women's occupations into modern (professional or cler-

Table 12. Median number of live-born children in two age groups, by urban-rural residence, and country type.

	Country type					
	Highly urban		Mixed		Highly rural	
Age	Urban	Rural	Urban	Rural	Urban	Rural
40–59	2.6	4.3	5.0	6.9	5.4	6.6
60+	2.8	4.7	4.8	6.3	5.0	6.0

Source: National census data prepared by INSTRAW.

Table 13. Average number of live-born children per woman, by level of education and age of mother at date of survey.

Educational level[a]	<20	20–24	25–29	30–34	35–39	40–44	45–49
Colombia (1976)							
No schooling	.6	1.7	4.0	5.6	6.0	6.6	7.4
Elementary	.2	1.4	2.6	4.2	5.1	6.3	6.7
Secondary	.1	.5	1.4	2.6	3.9	4.4	5.1
Costa Rica (1976)							
No schooling	...	.9	3.0	4.0	6.2	8.5	8.9
Elementary	...	1.3	2.4	4.0	5.3	6.3	7.1
Secondary	...	.5	1.2	2.3	2.8	3.7	3.6
Dom. Republic (1975)							
No schooling	.4	2.1	3.4	5.3	6.5	7.5	7.0
Elementary	.7	2.3	3.4	4.8	6.5	6.3	6.7
Secondary	.5	.3	1.3	2.1	4.1	3.4	3.0
Jamaica (1975)							
No schooling	...	1.5	3.4	1.0	4.9	4.8	3.4
Elementary	.7	1.9	3.3	4.5	5.4	5.7	5.8
Secondary	.4	1.0	1.6	2.1	3.2	3.1	3.4
Mexico (1976)							
No schooling	1.3	2.1	4.2	5.9	7.0	7.5	7.3
Elementary	1.0	1.6	3.2	4.7	6.2	6.7	7.1
Secondary	.8	.6	1.6	2.4	3.7	4.0	3.5
Panama (1975/76)							
No schooling	...	1.6	4.2	4.9	7.2	7.2	7.2
Elementary	...	1.7	3.4	4.5	5.5	6.3	6.4
Secondary	...	.7	1.8	2.7	3.6	4.1	3.8
Paraguay (1979)							
No schooling	.3	1.7	3.5	5.3	5.9	7.1	7.3
Elementary	.2	1.1	2.3	3.6	4.7	5.9	6.2
Secondary	0.0	.6	1.3	1.9	2.7	3.2	3.2
Peru (1977/78)							
No schooling	.3	1.6	3.1	4.9	6.7	7.2	7.6
Elementary	.2	1.2	2.9	4.3	5.2	6.2	6.5
Secondary	.1	.6	1.5	2.6	2.9	3.8	4.1
Venezuela (1977)							
No schooling	—	1.4 —	—	4.6 —	—	7.3 —	...
Elementary	—	0.9 —	—	3.5 —	—	5.4 —	...
Secondary	—	0.3 —	—	1.9 —	—	3.5 —	...

Source: Pan American Health Organization, 1985a, Table 4-17, p. 20.

[a] Elementary is one or more years of elementary schooling, secondary is one or more years of secondary schooling.

Table 14. Mean number of children ever born to ever-married women, by most recent occupation since first marriage.[a]

Country	No work	Modern	Transitional	Mixed	Traditional
Colombia	4.45	2.33	4.39	4.00	5.99
Costa Rica	4.44	2.34	4.84	3.72	6.51
Dom. Republic	4.03	3.31	4.13	4.14	6.28
Ecuador	4.25	2.25	4.54	4.15	5.56
Haiti	2.66	2.72	2.33	3.75	4.08
Jamaica	3.92	2.64	4.26	4.24	6.02
Mexico	4.50	2.63	5.22	4.58	6.08
Panama	4.39	2.50	4.46	3.70	6.25
Paraguay	3.75	2.29	2.96	3.76	5.23
Peru	4.18	2.64	4.51	4.66	5.54
Trinidad and Tobago	3.99	2.55	4.14	3.68	6.19
Venezuela	3.69	2.48	5.00[b]	3.39	4.23

Source: United Nations. *Women's Employment and Fertility.* ST/ESA/SER.A/96. New York, 1985.

[a] The definition of work used in the World Fertility Survey does not include housework. The "modern" occupational group includes women who were coded as professional or clerical workers. Those women are generally employed by someone other than a family member and work away from home for a wage or salary. The "transitional" group (household and service workers) also generally work away from home for someone other than a family member but use traditional skills requiring little education. Women in the "mixed" group (sales, skilled and unskilled workers) may work at home or away. They are often self-employed and perform jobs that require some level of training or skill. The "traditional" group is composed of women who work in agriculture. These women are often employed by a family member, have little education, and live in rural areas. Entries refer to ever-married women with one birth or more, by occupation since first birth.

[b] Category contains less than 20 cases.

ical workers), transitional (household and service workers, using skills requiring little training), mixed (sales, skilled or unskilled, self-employed, or jobs that may require some training), traditional (including unpaid work for family members, often in rural areas), and no work (housework only). These data come from the UN world fertility surveys undertaken in several developing countries in the late 1970s and early 1980s. Data from these surveys have provided much interesting new information on patterns and reasons for women's fertility behavior. As can be seen in Table 14, women in the modern category, probably holding professional or technical jobs that require higher education and training, have the fewest children, while those in the traditional category have the most.

Although at first glance it may seem that women who do not work at all would have the most children, this is not the case. First, the no-work category may also include upper-class women who practice family planning. More importantly, the traditional category is composed mainly of rural women. Rural settings, with their heavy emphasis on adherence to cultural prescriptions, are a potent factor that independently and powerfully works to perpetuate the pattern of large families.

The study also found that the relationship between occupation and fertility was strongest in countries at higher levels of socioeconomic development—the highly urban countries in the scheme used in this report. This indicates that not only the type of job performed but the geographic location plays a role (PAHO, 1986a, p. 15).

EDUCATION AND LITERACY

General Considerations

Of all the developing regions of the world, Latin America and the Caribbean come closest to approximating the ideal of universal education. Enrollment rates of girls and boys are high by developing world standards (between 44 and 97%); male-female ratios are close to equal; and, in some cases, girls' enrollment even surpasses boys'. Beyond enrollment, however, actual information on such factors as dropout, attendance, and completion rates; kind of education received; and highest level attained is very difficult to obtain. There is no consistent determination from one country to the next about what constitutes primary school. Thus, in Brazil, primary school is considered to be eight grades, while in Colombia it is five. In Honduras, the Dominican Republic, and several other countries, primary school is considered to be six grades in urban areas and three in rural zones. In the 1950s, when many of the current women at midlife would have been attending school, the national censuses do not report any definition of number of years of schooling constituting primary, intermediate, or secondary, yet they report numbers of children in each category (Parada, 1988).

Yet enrollment rates are not enough to determine women's educational level; if equality is at issue perhaps a better question would be how would girls' attendance rates be affected differently than boys'? In a study of factors affecting young girls' school attendance in the developing world, Chamie (1983) cites a number of general problems, many of which apply in Latin America, including:

- the uneven distribution of primary schools, especially in rural areas, making girls' attendance difficult since they are typically not allowed to travel as far as boys for schooling;
- a shortage of teachers and a general reluctance among certified female teachers to work in isolated areas or in urban slum areas where girls' school participation is particularly low;

- the perceived irrelevance of primary school curricula to women's employment possibilities and the general lack of opportunities in the labor market for educated women;
- the lack of emphasis in primary school curricula upon the value of basic educational skills acquired through primary school training to girls' future adult roles, e.g., numeracy, literacy, verbal expression, categorization, and conceptualization;
- school hours conflict with the demand for girls' household work and for seasonal labor responsibilities in agricultural and other types of production;
- late entry and sporadic attendance in primary schools complicated by the increased likelihood of pregnancy and/or preparation for marriage;
- rigid and unreasonable examination and promotion requirements (considering the child's living and work environment) that lead to higher dropout or repetition rates. Many boy repeaters take up class space that potentially could be utilized for new girl recruits into the system who are of the appropriate age for primary school attendance (p. 3).

Although some of these problems are less relevant currently in Latin America than they once were, the cohorts of midlife and older women who attended the school systems in the 1930s or earlier would certainly have found them applicable.

Women's Literacy

Literacy rates give some indication of the level of education of women on a national level. Literacy rates for women are displayed for urban and rural settings by country type in Table 15. Although the data refer to the 1970s, they include all those 10 years and over, thus midlife and older women would be included.

Literacy—whose meaning often differs from country to country, but generally refers to the ability to read and write—may be an inadequate predictor of life success for several reasons, however. First, it may not be retained. Experts say that four to five years of schooling are necessary for maintaining literacy skills (Chaney, 1984 p. 43). This means that crash campaigns to increase literacy have merely inflated the country percentages without truly benefiting the participants. Women in particular tend to lose the skills of reading, writing, and numeracy as they have less opportunity to use them.

Also, the type of education represented by literacy does not translate into training for employment, again particularly for women. For this, depth and practice are important and these are typically not available at the primary level where literacy is established. Finally, type of education is not addressed in literacy statistics, nor, for that matter, in primary-school completion rates. Too often the emphasis for boys in late primary school and secondary school is on math and science, while for girls, whose anticipated roles are homemaker and mother, classes in home economics are the norm (Chaney, 1984).

Rural-Urban Differences in Women's Literacy

Table 15 clearly shows the overall effect of rural-urban differences. First, when country types are examined, average literacy rates for women decrease as the countries become more rural. Also, within country types, rural-urban differences are large and consistent, so that rural women in rural countries are clearly the most disadvantaged, with a median of only 41%.

Some indication of the educational status of older women can be found by examining literacy rates of those over 35 years of age in rural and urban settings. Chaney (1984) points out that in younger age groups, literacy rates between men and women are more equal, with countries having low rates for women also having low rates for men (Guatemala and Bolivia are exceptions). After age 35, however, the rates tend to differ more, with several patterns emerging.[6] According to Chaney:

> Women's age-specific literacy rates fall roughly into three modal patterns of rural/urban differentials by age. In type I, the pattern is high urban literacy in all age groups (not falling below 75 percent literate, even among the older women), and a pattern of high literacy among the younger women in rural areas, but with steady declines after age 30—never, however, falling much below 50 percent literate at the older ages. Type I countries following some variation of this pattern include Chile, Colombia, Costa Rica, Panama and Paraguay. The decline in literacy after age 50 is more precipitous in Panama and Paraguay than in the other [three] countries, and the urban literacy rates are not so high in Paraguay as in the other four.
>
> Type II countries (Bolivia, Brazil, El Salvador, Guatemala, Honduras, and

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[6] Five countries at the high end of the mixed country category—Puerto Rico, Mexico, Brazil, Colombia, and Peru—show extremely high rates of past and projected rural to urban shift among midlife and older women. A large variety of factors could be operating to produce this effect and, with no means to sort them out, we simply note this fact for future exploration.

Table 15. Median percent literate; females over age 10 by residence and country type.

	Residence	
Country type	Urban	Rural
Highly urban	90	68
Mixed	89	59
Highly rural	79	41

Source: Adapted from Chaney, 1984, Table 4.1, pp. 56–57.

Nicaragua) show extreme contrast between rural and urban literacy rates, indicating that attention to rural education seems to have been neglected in favor of the cities and towns, at least until recent times. Urban literacy for women registers high, especially at the younger ages (although not so high as for type I countries), but rural rates are lower, even at the younger ages.

Type III countries (Ecuador and Venezuela) fall in the middle; they demonstrate less contrast between rural and urban areas, but show a steep rise in literacy between age groups, particularly in the rural rates. For the remainder of the countries, age-specific literacy rates by rural and urban residence are not available (Chaney, 1984, p. 45).

Education of Midlife and Older Women

Although school completion data for women at midlife and older are not widely available and of questionable comparability, Table 16 summarizes what could be found on completion of primary schooling in cohorts approximating those used in this report. Averages were not used in this case because so few countries had data and because of the problems of adjustment and comparability. However, data are presented by countries in order of their urbanization in the framework used in the report.

It can be seen in Table 16 that in all countries for which data are available—except Uruguay where the reverse is true—proportionately more men than women in the age groups over 45 have completed primary education, in both urban and rural settings. The reverse is true in Uruguay. Consistent with the information on literacy presented above, persons living in rural settings show lower educational attainment, and very low percentages can be found in all three country types. Also following the above pattern, younger cohorts generally have more education than older ones, and still younger cohorts (not shown in the table) usually have more education than the 40 to 59 year olds. It is clear that educational completion is improving, which is good news for women who will

Table 16. Percent finishing at least primary level education by country type, selected age groups, residence, and sex in 1980s.

		Urban						Rural					
		Age in 1980s[a]											
		45–59		60–74		75 +		45–59		60–74		75 +	
Country type	Country	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Highly urban	Uruguay	42.9	46.9	39.8	40.6	32.2	35.2	30.8	33.0	26.5	30.0	19.2	24.2
	Cuba[b]	65.1	53.9	42.1	36.7	—	—	32.0	17.4	13.0	9.0	—	—
	Brazil[b]	48.2	42.1	36.1	30.1	—	—	12.6	10.5	8.1	5.7	—	—
	Colombia[c]	48.4	41.6	39.1	34.9	—	—	9.4	7.8	7.8	5.9	—	—
Mixed	Peru	42.4	32.6	36.3	32.4	31.3	25.9	10.6	2.9	6.7	1.7	4.3	1.1
	Panama[d]	70.9	67.5	58.0	53.0	—	—	21.0	12.2	8.2	6.1	—	—
	Costa Rica[c]	56.8	50.0	41.4	35.7	—	—	14.8	12.2	8.2	6.1	—	—
Highly rural	Guatemala[c]	31.4	25.2	26.4	22.6	—	—	4.7	3.1	3.8	2.6	—	—

Source: U.S. Bureau of the Census International Data Base and census data compiled by INSTRAW.

[a] Some of the data are from earlier periods, and the age groups were adjusted to reflect the age the individuals would be in the 1980s.

[b] Upper group is 60 and over.

[c] Age groups are 45–64 and 65 and over.

[d] Age groups are 45–54 and 55 and over.

be at midlife and older at some point in the future, but it does not help those currently at these life stages.

To see whether literacy rates bore any relationship to completion rates, an effort was made to trace the patterns identified by Chaney when women over 35 are disaggregated into midlife, older, and very old as they are in Table 16. In all cases, rates of primary school completion were considerably lower than rates of literacy reported by Chaney. Of the countries in Chaney's Type I group represented in Table 16, only Panama displays the pattern of high urban primary completion and relatively high rural primary completion as well among older women. Rural rates for Chile and Costa Rica at these advanced ages are still abysmally low. Countries in the Type II category for which data are available (Brazil and Guatemala), however, do display a considerable difference between urban and rural completion rates as do those in Chaney's sample. In fact, for primary school completion in the older age groups, the pattern in most countries in this small sample is that of Chaney's Type II countries when information about literacy is considered.

A discussion of this sort can only be undertaken with the clear understanding that the data are not comparable in any way except to conceptualize patterns. Although they come from the same source, the Center for International Research of the United States Census Bureau, they refer to different questions (literacy and school completion) at different time periods (1970s and 1980s). The tantalizing possibilities for an increase in understanding of how education affects life for women in the Region should place high priority on a truly comparable study of these issues. In the meantime, however, where primary school completion of midlife and older women is concerned, rural and urban differences are still more like chasms than gaps.

Postsecondary and Professional Training

For most women currently at midlife or older, university training was out of the question. They were lucky to complete four to five years of schooling. The advantages of postsecondary education, when it was available, were generally reserved for those of middle-to-upper-class women who could afford the drain on family income and the income forgone. Careers chosen were generally an extension of women's roles—teaching, social work, fine arts, humanities, and social sciences. Medical sciences such as dentistry, nursing, pharmacology, and medical technology were also popular where they were available (Chaney, 1984, Table 4.8, p. 64).

For the still very small group of women lucky enough to reach this level, the situation is improving. Table 17 shows the increase in the percent of women enrolled from 1960 to the 1970s. In the earlier time period, women currently entering midlife would have been part of this university-educated group. For those now approaching midlife, who attended university in the 1970s, the picture had improved—substantially in cases such as Cuba, Colombia, Ecuador, Bolivia, and Haiti. Only in Costa Rica did the proportion of enrollment fall, but it still remains among the highest in the Region. In some countries, most often among the mixed and highly rural categories, percentages, although higher than in 1960, remain low. Those with percentages below 30 in the 1970s include Mexico, El Salvador, Guatemala, and Honduras. I was in Honduras from 1967 to 1969 helping to establish a university-level program in nursing education and can attest to the resistance and hardship faced by young women at this educational level, even in a "women's occupation" such as nursing.

It is important to remember when looking at this table, however, that the population from which these percentages are drawn is very small, and the potential population of university students is very large. Costa Rica has one of the highest percentages of women university students in the

Table 17. Percent of women among students enrolled in universities in 1960 and 1970s in selected countries.

Country type	Country	1960	1970s
Highly urban	Argentina	33	43
	Chile	35	38
	Venezuela	31	41
	Cuba	20	36
Mixed	Brazil	25	38
	Mexico	15	26
	Colombia	18	39
	Peru	27	35
	Nicaragua	20	32
	Dominican Rep.	28	40
	Panama	43	46
	Costa Rica	45	41
	El Salvador	21	25
Highly rural	Ecuador	18	33
	Paraguay	32	39
	Bolivia	17	42
	Guatemala	9	19
	Honduras	21	28
	Haiti	12	30

Source: Adapted from Chaney, 1984, Table 4.7.

Region (41%). Still, this represents only 1,640 persons out of a population of potential women students between 15 and 24 years of age in Costa Rica in 1984 of 271,380. Of course, similar restrictions on access to a university education apply to men. However, not only are a larger percentage of them accommodated, but the range of options in technical, administrative, and other types of careers requiring postsecondary but subuniversity education is much larger.

The Need for Improved Education for Women

That education is a crucial factor in increasing women's status in society and improving the conditions under which they live is clear. That it has far-reaching societal implications as well is beginning to be realized. Chaney (1984) reports a study conducted by Harrison in 1977 which correlated levels of mother's education with infant mortality (birth to 2 years) in the city of San Salvador. She found that the death rate for children of illiterate mothers was 184 deaths per 1,000 children, while the child death rate for mothers with seven or more years of education dropped to 37 per 1,000. Obviously, other factors such as occupation, income, marital status, and class probably had an impact on this dramatic decrease as well as education. The point is that these factors, in large measure, *also* are a function of educational attainment.

A university education is not required to learn the benefits of child spacing, proper nutrition, immunizations, and treatment of preventable causes of infant death. But it does require a basic grasp of language and numbers and the broadened world view that formal education fosters. Thus a firm primary education and, preferably, secondary school completion for all women will benefit not only the women themselves, but the society in which they live as well.

ECONOMIC SITUATION

The majority of women in Latin America work—sometimes from the time they are six years old until they die. Bunster and Chaney (1985) in a discussion of the plight of women street sellers in Lima, Peru report that the women often have to guard their wares by sleeping next to them while hiding from police. Quoting one of their informants, "Some old *ambulante* women have been found dead in their hiding place. They're too old and have worked too hard, they can no longer take it" (p. 104).

There is a difference between work and employment, however—employment is remunerated. Sometimes the work that women do is remunerated. More often it is not. Before presenting data on the economic situation of women at midlife and older, it is important to understand the sources of bias, underreporting, and exclusion of women of *all* ages from official employment records. This makes a coherent analysis of the economic situation of women in the older age groups a difficult task at best, and increases the potential for inaccurate generalizations.

Underreporting of Women's Work

Official statistics for recording economic activity are based on the 1980 recommendations of the Committee for the Improvement of National Statistics of the Inter-American Statistical Institute and on those issued by the United Nations Statistical Commission in 1977. They have been designed using a model that applies to men in politically stable, developed countries. The norm is based on paid employment for eight-hour days, five-day weeks, and a work year of 48 to 52 weeks (Recchini de Lattes and Wainerman, 1986; Aguiar, 1986). It has been clear and frequently noted for many years that women's work is of such a nature that it is not captured by the methods currently in use in national censuses (Ware, 1986; Mallon, 1987). Recchini de Lattes and Wainerman (1986) summarize the problem:

> The invisibility of adult women workers in these statistics is related to the nature of their work, their gender roles, and the assumptions about the labor force that shape the design of the statistical information. A large proportion of women's work in developing countries is discontinuous, part-time, seasonal, frequently difficult to distinguish from domestic activities, performed within the traditional sector of the economy, in family enterprises, or self-employing. The economic role assigned to women is perceived as marginal whenever a sexual division of labor defines the economic leadership as male (p. 747).

For official purposes, economic activity is defined as the "production of goods and services during the time-reference period chosen for the investigation" (Recchini de Lattes and Wainerman, 1986, p. 747). Unemployed as well as employed persons are included in the category. Employed persons are classified as all those having a job during the reference period (in most cases one week prior to the interview), including unpaid family workers, those on vacation, strike, and those ill, or temporarily absent for other reasons. Unemployed persons are those looking for work, not currently looking because of illness, or because they feel jobs are unavailable, and those who have made arrangements to start working in the near future. Those persons classified as economically *inactive* include full-time housewives, students, retirees, pensioners, and those confined to prisons or hospitals (Recchini de Lattes and Wainerman, 1986). Given the breadth of the category of economically active, and the fact that most census questions are structured so that they elicit answers to activity before inactivity, it would seem difficult to place many persons in the inactive category. Yet adult women's rates of economic activity are consistently low, with an average of approximately 25% overall in Latin America and the Caribbean and a range from 8.1% in Guatemala to 51.3% in Bermuda (ILO and INSTRAW, 1985, pp. 74–75). Chaney (1984), however, quotes a 1978 United Nations report that estimates women's true rates of participation in certain rural areas of Latin America as between 50% and 60%. In 1981, Buvinic compared household surveys carried out in several Latin American cities with census reports and found rates of urban participation from 14% to 30% higher than official counts (Chaney, 1984, p. 74).

Reasons for Under-enumeration

Several factors apparently account for the under-enumeration of women in the economically active category. For instance, the classification of unpaid family worker is particularly discriminatory towards women. Wives frequently work in small family businesses and, until very recently, to be counted as economically active in this category, workers had to be employed at least one-third of the hours considered normal for the particular country. This is in contrast to those who defined themselves as employees or self-employed, who only had to have worked one hour during the reference period (UN, 1984b). This problem is especially relevant in rural areas where small-holder agriculture is usually carried out by the entire family. Only the head may be counted, however, even though wives and, frequently, older children should also qualify as unpaid family workers.

Self-definition is another problem that hits women especially hard. Since the prestigious cultural roles for women are housewife and mother, and, in some cases, working outside the home is considered inappropriate, a census taker's question must be carefully worded if it is to elicit any economic activity. In many cases, the census instructions are to stop at the *first* affirmative answer in a list of possible activities. If "housewife" comes before other types of work the woman might have also performed, she will be misclassified. It is interesting that many of the countries have adopted practices that favor reporting economic activity if it exists, even before UN guidelines recommended the step (UN, 1984b).

Period of reference also poses a problem. Although the majority of countries in Latin America use one week prior to interview as the period of reference, in the countries where a longer period is used (Haiti uses six months), the official percentage of economically active women may be much higher. This is true of men, of course, as well, since it allows for part time, temporary, and seasonal work to be reported. The increase, however, is much greater for women, as a large majority of men are already recorded as economically active (Aguiar, 1986).

A recent concern also centers on the issue of underemployment. Because Latin America is more highly urban than many other parts of the developing world, this seems to be a particularly relevant issue in the region. (Recchini de Lattes and Wainerman, 1986). The migration to cities with its attendant marginalization of large numbers of persons forces many—especially women—into involuntary part-time rather than full-time work in jobs that pay poor wages and may be at less than their potential skill levels (UN, 1984b).

Where older persons are concerned, Recchini de Lattes and Wainerman (1986) contend that many of the problems of unreliability of statistics that pertain to women apply to children and the elderly as well, since the characteristics of their labor force participation parallel those of women. They also report that in certain countries (Cuba and Costa Rica) the instructions for census takers were such that older persons were automatically classified as economically inactive, assuming a universal ability to "retire" from work after reaching advanced age. In Cuba this age was only 55, in Costa Rica, 65. Thus reliability of the information on older women is compromised on the basis of *both* sex and age.

Formal and Informal Sectors

There has been considerable discussion recently about the best means of classifying economic activity of both men and women in developing countries.

A terminology that has been widely adopted takes into account some of the difficulties with under-enumeration of women, as well as acknowledging the growing importance of small business and self-employment. This approach separates economic sectors into formal and informal. It has been used in the last 15 years to such an extent that definitions of the two sectors are rarely provided now, yet the meaning of the two terms is far from clear (ILO and INSTRAW, 1985; Bromley, 1978). Bromley (1978) has described the basic distinctions between the two as follows:

> Informal activities are a way of doing things characterized by:
> ease of entry;
> reliance on indigenous resources;
> family ownership of enterprises;
> small scale of operation;
> labor-intensive and adapted technology;
> skills acquired outside the formal school system; and
> unregulated and competitive markets.
> Informal sector activities are largely ignored, rarely supported, often regulated and actively discouraged by the government.
> The characteristics of formal sector activities are the obverse of these, namely:
> difficult entry;
> frequent reliance on overseas resources;
> corporate ownership;
> large scale of operation;
> capital-intensive and often imported technology;
> formally acquired skills, often expatriate; and
> protected markets (through tariffs, quotas, and trade licenses). (p. 1034)

Accounts of formal and informal sector activities of both men and women support this characterization. What emerges is a picture of formal sector employment dominated mainly by men, except in the least-skilled and lowest paid occupations; and informal sector employment in which, although women predominate, there is still considerable sex segregation of jobs with men occupying the more attractive positions (INSTRAW, 1985; Bunster and Chaney, 1985; Tiano, 1984; Duarte, 1988).

A study prepared by the North-South Institute attributes the growth of the informal sector to: "changes in the rural areas leading to the displacement of paid agricultural labor, and the deepening of rural poverty and rural-urban migration; changes in the nature of industrial production leading to the displacement of cottage and handicraft industries; and the limited capacity of formal enterprises to absorb rural migrants and new entrants in the labor force" (INSTRAW, 1985). A recent study of women's labor force participation in the Dominican Republic documents many of the above changes and concludes that women's increased participation in the informal sector is a survival strategy in direct response to the economic crisis that has affected much of Latin America and the Caribbean throughout the 1980s (Duarte, 1988).

Women Predominate in the Informal Sector

It is easy to see how these two sectors would attract men and women unequally. Mechanization of agriculture has taken the form of technologies appropriate to men (heavy equipment such as tractors) so the displacement of agricultural workers has been greater among women. These women constitute a steady stream of young women who, for financial reasons, migrate to the cities looking for formal sector work. In the formal sector, studies show that the range of occupations open to women is much narrower than that available to men, and that women are overrepresented in the lowest paying, lowest prestige jobs (Chaney, 1984; Duarte, 1988).

Thus, the work these women find is usually in the informal sector, at least initially, and is frequently an extension of their traditional tasks (Wainerman, 1985). Activities include small-scale handicraft production, food preparation and vending, petty trading, domestic service, and sometimes prostitution. Ease of entry is important initially and becomes critical as the women begin having children to provide for while they earn an income.

In terms of the other characteristics listed by Bromley (1978) above, we have seen that women—especially midlife and older women—are less educated, or at least have less applicable skills for formal sector employment than do men. This lack of skills makes women's labor their major, and sometimes only, asset. Women generally lack access to credit which makes it impossible to obtain capital that could be used to purchase equipment and use technology to increase the scale of operations (Bunster and Chaney, 1985). Thus the scale remains small and the resources used are indigenous. On all counts, women appear to be "naturals" for the informal market.

Because the informal sector is a shifting and fluid entity, and women move in and out of it, it is very difficult to know how much of the labor force is employed here, and of that, what proportion are women. Bunster and Chaney (1985) report a 1978 study of women's employment in Latin America conducted by the Oficina Internacional de Trabajo in Santiago, Chile, which states that over half of the female work force in Latin America is employed in the service sector. Within this, the major job category is domestic service, usually considered an informal sector activity, employing between 50% and 70% of women. Domestic service, in fact, accounts for between 30% and 45% of the total urban female economically active population.

Duarte's (1988) study of the work force in the Dominican Republic showed that in 1981, of every 100 women economically active, 54% were employed in the "tertiary" sector, of which the informal sector forms a major part, 12% were employed in mining, manufacturing, and construction and 8% in agriculture. In the city of Santo Domingo, the proportion found in tertiary sector activities rose to 85%, divided between social and personal services (60%) and commerce (22%). A recent study of women's work in Mexico found that 91% of the sample of 122 women were migrants, 65% of whom came to the city between the ages of 10 and 18, and 65% were employed as domestics (Sanchez and Torres, 1987).

Working conditions in both domestic service and street or market selling have been documented by Bunster and Chaney (1985), and, particularly poignantly, in a series of testimonies published by the Sindicato de Trabajadoras del Hogar de Cusco (1982), a union of domestic workers in Peru. Sixteen- or eighteen-hour days, poor or nonexistent pay, little free time, and overwhelming work burdens are the norm. Added to this is the low regard in which they are held and occasional beatings to which domestic servants are subject.

Older Women in the Informal Sector

What happens to the older women in a structure such as this? Bunster and Chaney (1985) maintain that frequently when the domestic worker becomes pregnant with her first child she is rejected by the *patrona*. Even when allowed to remain in domestic service, if she lives in or brings her child with her, she frequently must keep her own child out of sight and unsupervised while she cares for the children of the family she works for. Evidence indicates that most women seek other employment when they start their own families—most often as vendors because of the flexibility and independence this type of work provides.

Jelin's early study (1987) included information on both migration and economic participation for Chile and Brazil. The same pattern was evident in both countries: higher participation rates were found among more recent migrants. This pattern was particularly strong among younger women. As they grow older, Jelin speculates that they leave "either to become housewives or to move to other occupations" (p. 134). Bunster and Chaney's data on 36 street and market vendors showed that 39% had at one time been employed as domestics.

The most recent work by Young (1987) corroborates the other two studies. Young reports that although both domestics and vendors share such characteristics as rural highland origin, they differ in age, educational level, and family status. The vendors she studied in Lima tended to be older, less educated women who were responsible for children. Arizpe

(1979) noted much the same thing in Mexico City almost 10 years earlier. She adds that "it is extremely rare for old women to enter domestic service; the possibility of inefficient work and illness makes employers reluctant to hire them" (p. 33).

A quote from one of Bunster and Chaney's (1985) interviewees summarizes the situation from the perspective of the vendor. A peddler who has sold different products for 30 years says:

> Each day you have to struggle, you have to be on your feet running after your customers. When one is a young girl tiredness is not felt because peddling seems like a game, one has a good laugh every now and then and the illusion that everything is going to be fine. When one becomes older and more mature one realizes that there is no hope, that days are all the same, one tires early of sitting and vending, standing, running after customers. Sometimes we don't even know what time it is, nor the day of the week and the buzzing noise of the people in the market becomes intolerable (pp. 80–81).

Women's Participation in the Formal Sector

Even when information about the economic activity of women at various life stages is available, there is no agreement on exactly what it means. Several opposing interpretations of the information about women's participation are summarized by Tiano (1986).

> Heated debate surrounds the issue of the effects of industrialization on Latin American women. Current viewpoints can be subsumed within three competing perspectives. The "integration thesis" holds that industrialization leads to female liberation and sexual equality by involving women more centrally in economic and political development. The "marginalization thesis" maintains that capitalist industrialization excludes women from productive roles and confines them to the household or to the informal sector. Finally, the "exploitation thesis" claims that industrialization creates a female proletariat supplying low-wage labor for accumulating capital at minimal cost (p. 158).

Although these perspectives are not mutually exclusive, and each one has kernels of truth, for midlife and older women, the marginalization and exploitation viewpoints seem to come closer to the mark. The available data on women's participation will be examined in two ways to get at the situation of midlife and older women. First, trends in the pattern of activity for women at later life stages over time (a longitudinal approach) will be presented. Then patterns followed by women in the process of reaching midlife and older (a cohort approach) will be discussed. Data for this section were taken from the 1986 edition of the International labor office's *Economically Active Population*. Four countries were excluded from the analyses in this section because their information was felt to be noncomparable with the others (Parada, 1988; Recchini de Lattes and Wainerman, 1986). The countries and reasons for exclusion are: the Dominican Republic, which lacked any definition of economic activity or period of reference; Costa Rica, where period of reference was one month instead of one week and where the wording of the question about economic activity was left up to the census taker; El Salvador, where the census taker was also not given instructions; and Haiti, which used a six-month period of reference. Three of these countries fall into the mixed category and one, Haiti, is part of the highly rural category.

Table 18 displays the median percent economically active women for selected ages from 20 to 65 at two time periods—1950 and 1980—within country groups. It also shows the percent change between the time periods. This provides a comparison over time for both younger and older women and illustrates changes that have taken place during the 30-year period in which much of the industrialization discussed above took place.

The table shows that, with two exceptions, the greatest increases in participation rates over time took place in the highly urban countries. The exceptions were in the 20–29 and 50–59 year-old cohorts, where increases were greater in the mixed country type. This is consistent with the previous hypotheses of decreasing work in agriculture sending women to the cities in search of new means of economic survival. It is also true that formal sector employment is more available in the cities, particularly for women. Thus, in highly urbanized countries, it is reasonable that larger increases would be seen at all points across the life span.

Table 18 also illustrates that participation rates are higher in the urban countries at both time periods almost without exception among the younger age groups than they are for the other two country types. Beginning at age 50, however, separate trends emerge. First, participation rates between age groups fall sharply in 1980 for women in highly urban countries, perhaps in part reflecting the female mandatory retirement age of 55 years in many countries. A second trend, perhaps related to the first, is that in 1950, beginning at about age 60, women's participation rates are higher in mixed and highly rural countries. Even in 1980 this trend continues in the older age groups. Starting at late midlife a third pattern emerges. Employment rates are generally low and differ little among the country types. This suggests that if the "integration thesis" described by Tiano (1986) holds for women at all, the benefits of industrialization accrue mainly to younger workers.

Table 18. Median percent economically active women and percent change over time in selected ages 20 to 65 and over, 1950 and 1980, by country type.

Country type		20–29		30–39		40–49		50–59		60–64		65 +	
		1950	1980	1950	1980	1950	1980	1950	1980	1950	1980	1950	1980
Highly urban	% Active	28	43	20	40	19	34	17	22	10	12	8	4
	% Change	54		100		79		29		20		– 50	
Mixed	% Active	22	36	19	32	19	30	15	20	13	14	9	6
	% Change	64		68		58		33		8		– 33	
Highly rural	% Active	18	24	15	22	16	20	18	16	16	13	12	7
	% Change	33		47		25		11		– 19		– 42	

Source: Adapted from ILO (1986).

Another observation about the information in Table 18 is that in the highly rural countries, not only are participation rates low, but they also have not changed greatly over the 30-year period. As we have seen, this does not mean that women are not working; the most likely explanation is that they are working in subsistence agriculture and household production or bearing children, thus their work is not counted as formal employment for purposes of the census.

In terms of the age structure of the economically active female population, the pattern is the same as that reported in other studies in which the peak participation comes at ages 20-29 and decreases thereafter. One interesting difference is that the highest rate of increase over time in all three country types—strikingly so in the highly rural countries—has been in the decade between 30 and 39 years of age. Chaney (1984) reports that there is as yet no second peak of economic activity after 40 years of age in these countries as there is in industrialized societies when women reenter the labor market after their children are grown. She did not have access to data from the 1980 census round, and commented that such a peak might be seen in Argentina and Chile when these data were available. This does not appear to be the case from data prepared by the International Labor Office (ILO), published in 1986, and used in this study. It could be, however, that, given the large increase in activity of the 30-39 year-olds shown in the current data, a peak of this sort will appear in the 1990 census round.

One is tempted to speculate that in Latin America, because of the economic crisis of the 1980s and other considerations that make this Region unique, patterns such as the drop in economic activity during childbearing years and the peak after 40 will never be seen in census information as women will simply continue to work in order to survive. However, in the cohort analysis to follow, there is evidence in nearly half the countries of a dip in activity during the decade from 30 to 39. Activity after age 40 never reaches that of the 20 to 29 year olds, but it increases slightly over that of the previous decade in certain countries. Census data must improve before any confidence can be placed in these generalizations.

A final point of interest in Table 18 is that although median rates of economic activity among women decreased in all cases in 1980 and in most cases in 1950 after the decade from 20-29 years of age, participation rates over the 30-year period from 1950 to 1980 continued to increase in most cases until age 65 in urban and mixed countries and age 60 in rural countries, after which a decrease occurred. This decrease after age 60 was also noted by Chaney (1984, p. 74) from 1950 to 1970. She quotes the optimistic explanation offered by both the Inter-American Development Bank and the Inter-American Commission of Women that this is an indication that the participation profile of Latin American Women is becoming more like that of industrialized countries and that this behavior is typical of countries undergoing development. Her own explanation, however, is quite different. She feels that evidence from other studies indicates that women in older age groups are increasingly migrating to the cities, a view shared by Anzola-Perez (1985). Any work done after migrating at an advanced age would almost invariably be informal and unreported. She also reported ILO's feeling that older women are being forced out of the formal labor market because of employers' preferences for younger, better educated employees (p. 73).

Table 19 focuses on women at midlife and beyond in 1980 in order to see whether decreases in economic activity were related to the specific part of the later life span a woman was in. For ease of reference, the stages have been arbitrarily called early and late midlife and early and later old age. In all cases, there is a *decrease* in activity as age increases. However, the country types differ considerably in the pattern of these changes. In highly urban countries, the decrease between each age range is a relatively sharp drop, from 36% between early and late midlife, to 46% between late midlife and early old age and 65% between early and later old age. This pattern seems to support the assertion that older women are being forced out of the labor market, particularly in countries where women form a larger part of the employed population already.

The pattern is different for women in the mixed country category. After a drop of 34% between early and late midlife, the drop between late midlife and early old age is somewhat less at 28%. The same pattern of

Table 19. Median percent employed among early and late midlife and early and late old age, with percent change from previous age group by country type, 1980.[a]

		Midlife		Old age	
Country type		Early (40–49)	Late (50–59)	Early (60–64)	Late (65 +)
Highly urban	% Employed	33.5	21.5	11.5	4.0
	% Change		– 36	– 46	– 65
Mixed	% Employed	29.5	19.5	14.0	7.0
	% Change		– 34	– 28	– 50
Highly rural	% Employed	20.5	16.5	13.0	7.0
	% Change		– 20	– 21	– 46

Source: International Labor Organization, 1986.

[a] Four countries were excluded because data were not comparable: Dominican Republic, Costa Rica, El Salvador, and Haiti.

large decrease is seen, however, by age 65, with a change of 50% between early and later old age. In highly rural countries, where participation is low to begin with, decreases are relatively small between early and late midlife and between late midlife and early old age, 20% and 21%, respectively. However, the sharp drop observed in the other countries between early and later old age is seen in the rural countries as well, at 46%.

Using a cohort approach to the information which traces the patterns of employment for women as they age, Table 20 illustrates the overall pattern for Latin America as a whole. The table shows the percent of women economically active by cohort, from 1950 through 1980, beginning with those who were 10-14 years old in 1950 and following their activity until 1980 when they were 40-44 years old, just at the beginning of midlife as defined here.

Several things can be pointed out in this table. In general, participation rates for women already at midlife or approaching it in 1950 are relatively low and did not change much as they aged. Those in the cohorts from 10-14, 15-19, and 20-24 had higher rates and these increased over their life span. Clearly, by 1980, more work was available and a larger proportion of women were taking advantage of the opportunities, until age 55. Then the relatively sharp drop discussed earlier began. A much smaller proportion of those who were 35 to 39 in 1950 were working by 1980 when they were 65-69.

Tables of this kind were prepared for each country included in the analysis and can be found in Appendix 1. In an effort to locate patterns, countries were first divided into the standard categories of high urban, mixed, and high rural. Since this division did not produce clear patterns in the cohort analysis, the countries were divided according to whether the proportion of women becoming economically active increased on the

Table 20. Percent of economically active women in Latin America by cohort, 1950–1980.

Cohort age in 1950	Percent economically active in:				Cohort age in 1980
	1950	1960	1970	1980	
10–14	8	26	24	31	40–44
15–19	26	22	24	29	45–49
20–24	24	21	23	25	50–54
25–29	20	20	22	21	55–59
30–34	19	20	20	15	60–64
35–39	18	19	17	8	65–69
40–44	18	18	14	—	—

Source: International Labor Organization (1986).

average over time (Type 1), stayed about even (Type 2), or decreased (Type 3).

The nine Type 1 countries generally followed the overall pattern just described, in which the younger cohorts in 1950 had about equal increases in the proportion of their participation over time, while older cohorts either maintained or reduced their participation. In the five Type 2 countries, a relatively constant proportion of women was active over the period, both within and across cohorts. That is, women's proportion of participation did not increase as they aged, nor did any age cohort seem to participate more than others over time. This is true for all cohorts except the very youngest and the very oldest. In these cases, participation decreased over time.

In the two Type 3 countries, the proportion of economically active women declined over the period. The initial drop was shared by all cohorts, but older women's participation decreased more rapidly toward the end of the 30-year period.

Table 21 shows the percent of economically active women in just one cohort (that which was 15 to 19 years old in 1950) at two time periods: 1950 and 1980 for selected countries divided into the three types. Overall, the experience of this particular cohort is descriptive of the kinds of changes in economic activity that the types describe: increase in percent economically active for Type 1, little change for Type 2, and decrease for Type 3. Chile is an exception in Type 1 and Ecuador, and possibly Peru, are exceptions in Type 2. Although not presented in this Table, other cohorts from these three countries behave similarly.

This table illustrates how the experiences of participation in the labor force of women in the 15–19-year-old cohort as they age differ overall in the three country types. In Type 1 countries where industrial growth has been the rule, the experience of women has reflected this trend with increased economic activity. In the other two types, economic growth has been slow and women have not reaped the benefits of what growth took place.

When country types are cross-classified with the rural-urban divisions usually used, the relationship seen in Table 22 results.

It is important to remember the basis of each division in order to understand this relationship. Countries were originally divided into categories on the basis of the urban or rural concentration of women at midlife at one point in time, 1980. The country type division is based on a pattern of economic participation, over a period of 30 years, of women who are currently at midlife and older. It is not surprising that the two classifications do not completely overlap. What is clear from Table 22 is that the majority of the high urban and mixed countries fall into the Type 1 classi-

Table 21. Percent economically active among women aged 15 to 19 in 1950 in two time periods, and percent change by type of country.

	Year		
	1950	1980	% change
Type 1 countries			
Uruguay	31	38	22.6
Chile	28	28	.0
Venezuela	23	30	30.4
Cuba	23	30	30.4
Brazil	24	29	20.8
Mexico	15	29	93.3
Nicaragua	15	20	33.3
Panama	23	31	34.8
Puerto Rico	21	28	33.3
Type 2 countries			
Argentina	26	26	-3.8
Colombia	24	22	-8.3
Peru	29	26	-10.3
Ecuador	24	20	-16.7
Bolivia	23	23	.0
Honduras	15	16	6.7
Type 3 countries			
Paraguay	26	21	-19.2
Guatemala	17	12	-29.4

Source: International Labor Organization, 1986a.

Table 22. Cross-classification of pattern of women's economic activity by country type and by urban-rural country division.

	Highly urban	Mixed	Highly rural
Type 1	4	5	—
Type 2	1	2	3
Type 3	—	—	2

fication of countries in which the proportion of economically active women has increased over the last 30 years, while all of the highly rural countries fall into either Type 2 or Type 3, in which women's participation has either remained the same or decreased. One could argue that urban life is hard on women but, at least in terms of the opportunities for gainful employment, it seems to offer the best options.

Rates and Actual Numbers of Women Employed

Economic activity rates by themselves tell us little about the *numbers* of women employed. The difference between absolute and relative numbers of employed is brought into sharp relief by this assessment of the status of female employment in Mexico, conducted 10 years ago by Lustig and Rendon (1979).

> Between 1950 and 1970, total employment in Mexico increased 252%, the male labor force expanded 214%, and the female labor force about 1,034%. In proportion to total employment, the female labor force between 1930 and 1970 quadrupled, while the male labor force diminished slightly. Nonetheless, in 1970 women represented only 19% of the total, and less than one-fifth of the women in Mexico aged twelve or over devoted themselves principally to the production of commodities in return for pay.

For the entire Region, the rates are not as startling, but they show the same patterns. Between 1950 and 1980, the female percent of the labor force increased from 12.6 to 18.0, while that of males decreased from 57.4 to 50.3 (ILO, 1986a, pp. 14–15). In terms of numbers of persons, both increased considerably, but the increase for women was greater than threefold, from 10 million to 32 million, and for men it was less than two-fold, from 48 to 91 million. Even so, it is clear that the actual number of economically active men is three times that of women. Table 23 illustrates the net change in the labor force in Latin America at four time periods with projections to 2000. In this Table it is possible to compare actual numbers with percentages and get a sense of how far away women still are from sharing equally in the advantages of paid employment. It is important to keep this disparity in mind when acknowledging the gains made by women during periods of rapid development.

Table 23. Net change in labor force in Latin America; 1975, 1980, 1985, and 2000.

	Change in number (1,000s)		Change in percent	
Year	Men	Women	Men	Women
1975	32,139	12,419	68.2	120.2
1980	10,688	4,355	13.5	19.1
1985	12,435	5,531	13.8	20.4
2000	48,209	24,080	47.1	73.8

Source: UN data prepared by INSTRAW.

Differences Between Women's and Men's Work

There are major differences, as well, in the kinds of work men and women do. ILO statistics on the economically active population divide types of work into three broad sectors, agriculture, industry, and services. Table 24 and Figure 3 show the percentages of men and women in Latin America involved in each of these sectors.

As the last row of Table 24 demonstrates, while the percentage of men participating in agriculture has declined by about one-third (36%), for women, the percentage in agriculture has decreased by nearly half (47%) over the 30-year period. While the percentage of men employed in the industrial sector has increased by 49%, that for women has decreased 14%. In the service sector, the increase in percentage of the labor force for men is 54%, while for women, where half or more of the labor force was already in the service sector, the increase was still 31% over the period. It is clear that the distribution of both the male and female labor force in economic sectors has changed radically over the period. Figure 3 illustrates these changes.

The participation rates, as discussed earlier, mask a much larger percent increase in actual numbers of persons involved in a particular activity. The second to last row of Table 24 shows the percent increase of numbers of workers from 1950-1980 for each of the sectors for men and women. Thus, although the share of economically active women in agriculture has decreased considerably over the 30-year period, the percent increase in number of women involved in this activity has increased more than it has for men, 67% versus 23%. Likewise, although industry's share

Table 24. Percent of men and women economically active in Latin America by sector; 1950-1980.

	Men			Women		
Year	Agriculture	Industry	Service	Agriculture	Industry	Service
1950	59.0	18.8	22.2	27.4	22.6	49.9
1960	53.2	21.0	25.7	23.8	21.0	55.2
1970	46.8	24.2	29.0	18.0	19.8	62.2
1980	38.0	28.0	34.0	14.6	19.8	65.6
			Percent change, 1950-1980			
Numbers	23.0	185.0	193.0	67.0	175.0	313.0
Percent	-35.7	48.9	53.7	-46.7	-12.4	31.4

Source: International Labor Organization, 1986a.

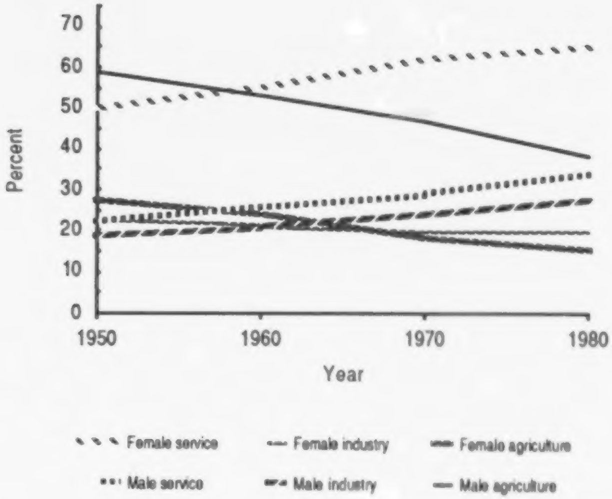

Figure 3. Percent distribution of economically active Latin American men and women by sector, 1950–1980.

of women's participation has decreased, the percent increase in numbers of women workers in this sector has nearly kept pace with men's, 175% versus 185%.

The service sector has been of most interest to Latin American scholars studying the situation of women in the area (Chaney, 1984; Bunster and Chaney, 1985; PAHO, 1985b; Recchini de Lattes, 1979) mainly because it is the area in which the majority of women in the formal (and informal) sector are employed. It is clear in Table 24 that this is the sector in which the largest percent increases in numbers of people have taken place over time, for both men and women, but considerably more so for women (193% versus 313%). We have already seen that for women of the lower classes, domestic service and vending are the major sources of employment. Although these are part of the service sector, they are not always included in the official statistics; thus, other activities must account for the increases in the service sector. For women with some education and, as Chaney (1984, p. 68) puts it, *buena presencia*, or a good (nonindigenous) appearance, such activities as secretarial work, clerking, sales, hotel and restaurant work, and low-level positions in banking comprise part of the service sector.

For women with a university education, the service sector also includes professionals of various kinds, but the range of professions available to women are limited and cluster in the areas of education, health and welfare, and commercial and business administration (Chaney, 1984; PAHO, 1985b, p. 30). Even as professionals, women tend to choose occupations that are extensions of "women's work."

Chaney (1984) also makes an interesting point about the settings in which women professionals choose to work. Government bureaucracies are places where women are often found in positions of authority and responsibility. Chaney reports that the women she has interviewed regarding this phenomenon report that because their male peers prefer the more lucrative private sector positions, there is less competition for high positions in government service (p. 68).

When women attempt to compete with men for the same positions, they find themselves at considerable disadvantage. Although information about discrimination in financial remuneration for equal work is understandably limited, that which exists shows clearly that wages are higher for men than for women. Data from a PAHO study show that in three out of the four countries studied, in the service sector where the majority of women are employed, average wages for men outstripped those of women, in one case, by almost 70%. This was attributed to the "fact that in all sectors of the economy men are more numerous in the highest-paying occupational groups and, within each group, they have the highest-paying jobs" (PAHO, 1985b, p. 38).

A particularly chilling analysis conducted by the ILO (1984) gives an example of the odds women face even when they manage to obtain advanced education. Information was available from four countries. In El Salvador, in the manufacturing industry in 1980 men earned an average of 23% more, while in agriculture, the discrepancy decreased from a high of 29% in 1972 to the 1980 figure of 13%. In Brazil, the income of the active male population was 67% higher than that of women even though, at the same time, women had, on the average, a 33% higher level of training than men. In Costa Rica, the difference in favor of men was 19% in 1980.

In Chile, women have an educational advantage over men in both urban and rural areas. Nonetheless, when the relationship between education and income was examined, it showed that the greater the educational level, the greater the income that men received in comparison to women. Thus, in 1979, the average income of men with no or basic education was 71% higher than that of women. With a high school education this increased to 84%, and with a university education, the average income of men was found to be 191% higher than that of women (ILO, 1984, p. 23).

THE FAMILY CONTEXT

Obviously women do not live or work in a vacuum. They relate to and are often responsible to a wide variety of others; not only their immediate families, but networks of relatives, neighbors, friends, and employers. A discussion of women in this context has been postponed until this point because, in a real sense, women at midlife and beyond sustain and are sustained by these networks—financially, emotionally, and socially—more than at any other life stage, and an understanding of their roles presupposes some knowledge of the influence of other factors such as education and employment.

Navarro (1979) reports the argument of some Latin American scholars who believe that women:

> cannot be studied in isolation from socioeconomic conditions as they exist in a peripheral, underdeveloped continent. Women must be situated in the specific characteristics of each Latin American country, in an urban or rural environment, in their class, and especially in their family (p. 115).

She quotes Jelin, who argues for the use of "household" as the unit of economic analysis so that women's work can be more accurately portrayed. Navarro feels that many authors find the household a useful category for analysis because it is the context in which most urban and rural women live, work, and raise their children.

Types of Families

As has been done with economic activity, scholars have tried to categorize families into "types" on the basis of kinship, size, function, or other criteria. A typology as popular as the formal and informal sectors in the economic sphere has not emerged yet; however, there is a trend in the literature on the subject toward an analysis of family type on the basis of kinship and function.

Beginning with the broadest classification, Bryceson (1985), in a discussion of the effects of technology on women, describes three main types of households. The first, the "rural, asset-holding households" are the most comprehensive in their function, as they serve as units of production, reproduction, consumption, recreation, investment, and social security. In a more familiar terminology, this is an extended family, and although women have few rights to property, they can still expect support from other members.

The second type of family is the "traditional informal sector household" representing an "amalgam of different tendencies in transition from rural to urban residence and employment." Bryceson sees this as the most unstable type of family and one in which the woman is vulnerable to becoming the head through marital breakup. These families are more often found in the lower socioeconomic brackets, and the fall-back position for women in this case is nonexistent since they are "separated from the natal family by distance or by the family's own economic hardship." Bryceson adds an interesting insight about technology in this type of family. She says that:

> while many technology designs are potentially useful to women in the informal sector, the purchasing power with which to buy them is frequently lacking. Moreover, government and official channels of technology dissemination may not reach these households because they often occupy geographical pockets of official neglect, e.g., urban squatter settlements (Bryceson, 1985, p. 41).

The last type of household described by Bryceson is the "urban formal sector household" which is "characterized by its disassociation from agriculture, the rural-extended family, and familial forms of social security" (p. 41). Income is derived from the wages of the (usually male) head of the household. Women are expected to concentrate their energies in reproduction and the home, although they are not prohibited from working if trained in a profession.

Bryceson points out that it is this type of family that usually employs maids for household work. Although there is little information on middle- and upper-class women in the literature, a study conducted in Uruguay by Campiotti (1983) has analyzed the amount of hours spent by various persons in unpaid household labor in 35 households ranked according to income, sector, and educational level. Table 25 and Figure 4 reproduce the interesting results. Unfortunately, it is not possible in this Table to separate out the work done by domestic help. As one might expect, the greatest percentage of time devoted to unpaid household labor is spent by women, and the greatest total number of hours per week is spent in the lowest strata families by both men and women in "personal survival activities," according to the author. However, the amount of time spent by the housewife alone does not display a consistent pattern, either of increase or decrease with increasing status of the household. In fact, in the highest status households (although there were only two) the housewife alone performed *all* the unpaid household work. This study challenges the assumption that as income and social status increase, the work done by the dominant female will decrease. As Figure 4 shows graphically, however, the assumption of decreasing household work with in-

Table 25. Average weekly time devoted by household members and nonhousehold members to unpaid household activities for 35 households in Montevideo, Uruguay.

Sector	Income	Educ.	Housewife only	Housewife & other women	Husband & other males	Total	N
			Hours per week				
Informal	Low	Low	64	74	38.5	112.5	7
Modern	Low	Low	48	61	36.5	97.5	10
Modern	Avg.	Avg.	55	61	5.5	66.5	11
Modern	High	High	26	33	8.5	41.5	5
Modern	Highest	High	49	49	—	49.0	2
			Percent of total time				
Informal	Low	Low	57.0	70.5	29.5	100.0	7
Modern	Low	Low	49.1	70.5	29.5	100.0	10
Modern	Avg.	Avg.	82.6	92.5	7.5	100.0	11
Modern	High	High	61.6	84.4	15.6	100.0	5
Modern	Highest	High	100.0	100.0	—	100.0	2

Source: Campiotti, 1983.

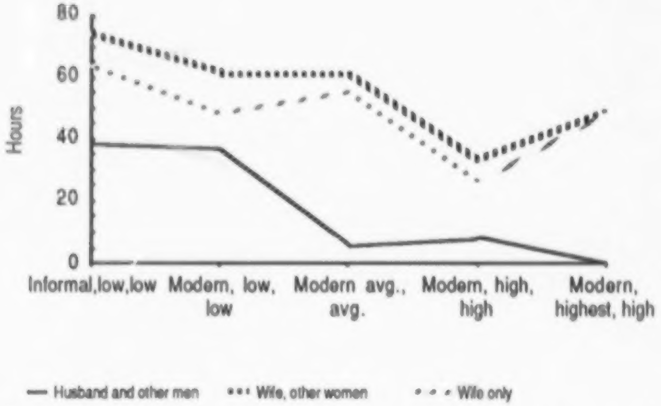

Figure 4. Average hours per week spent on unpaid household activities in 35 households in Montevideo, Uruguay, by sex, occupation type, education, and income.

creasing status holds very true for males. Once again, the information is not detailed enough to provide clues to the roles of other household members.

Household Size

Where women are concerned, household size has been viewed in various ways. In one respect, many children represent a burden, and we have seen that, at times, this has caused the dispersion of rural families. On the other hand, the presence of other household members may make it possible for women to employ economic survival strategies that might not otherwise be available to them. Table 26 shows the median urban and rural household sizes within country groups.

The lack of difference in average household size among countries and between rural and urban settings shown in Table 26 is striking. It is not, however, an anomaly. This pattern of overall continued large household size, particularly in the (Bryceson, 1985) "traditional informal sector household," has been noted by other authors and debated in the literature. Although the existence of an extended family system that could provide security to the elderly has been debunked as a "romantic myth" by some (Samarasinghe, 1982 quoted in Treas and Logue, 1986), other authors have felt that the perpetuation of an extended family in various forms was a survival tactic that provided critical support, particularly to women struggling to make ends meet (Nieves, 1979; Duarte, 1988).

In a study of slums in San Salvador, Nieves (1979) identified several types of households distinguished on the basis of the kind of bond or link connecting members. Two basic types with a number of variations emerged. Of her sample of 197 households, 79% were organized around one and sometimes two conjugal pairs. The other 20% were composed of

Table 26. Median family size by residence and country group.

	Residence	
Country type	Urban	Rural
Highly urban	3.9	3.9
Mixed	4.6	4.7
Highly rural	4.5	4.7

Source: Center for International Research, Bureau of the Census, 1988.

persons related by blood ties. These households were defined as "coresidential kinship groups which include no regularly present male in the role of husband-father" (p. 137). Persons linked by kinship form the nucleus of the household, and a woman could have a relationship with a man who sees her regularly but does not become part of the group. The males typically are sons, brothers, uncles, or nephews of others in the group. The most important relations are among the adult females who form the core of the household group.

This type of family arrangement is common in the Caribbean and in urban settlements (Nieves, 1979; Buvinic and Youssef, 1978). Its popularity in the urban setting seems to derive from the fact that there are more opportunities for employment for women in the cities. Nieves reports that of women between 10 and 65 years old, 33.5% were employed in urban areas, while only 10.5% held paying jobs in the rural areas. She adds that "because women are paid less than men, they can find work more easily; hence, women have more economic security than men" (p. 139).

We have seen previously, however, that this advantage is more than offset by the inequities in pay for equal work by men and women and by the fact that any employment women have is not only poorly paid, it is also added on to their household responsibilities.

Nieves argues that the kinship-based, rather than conjugal-pair-based family is more flexible and responds better to shifting economic circumstances. It is difficult for a family consisting of a mother, father, and unwed children to add to the group, while the more loosely organized family can absorb immigrant relatives or those in transit more easily. For women in the household, this ability to change has important consequences. Since they have always held more than one job to reduce the risk of unemployment, the physical mobility and flexible scheduling required of this life-style are made easier with more persons to share the household and child-care responsibilities.

The nature of this expandable group is also partly responsible for the continued large family size seen in official statistics according to Duarte (1988). Most censuses define households not in terms of family members, but as numbers of persons living together under one roof. Thus, the extended family of the kind described above would not necessarily reflect any decrease in fertility that may have occurred in recent years. Duarte also feels that this type of family arrangement has important survival value. In the Dominican Republic, where her study of women's labor force participation was conducted, although the number of children decreased as social class increased—from an average of 8 among women 35-49 in the lowest classes to 4.6 among the same age group in the highest class—the average family size overall in the country remains at about 5.3. She attributes its continued size to the persistence of the extended family household as a survival strategy in the popular sector in face of the continued economic crisis that afflicts the country.

In the English-speaking Caribbean, a similar pattern prevails. A study carried out by the University of the West Indies found three common types of unions. Visiting unions, where joint decisions are made and contact between father and children is relatively frequent, are common among younger women. Common law, or higher status married unions, occur more often among older women. A finding that seems to indicate a practical approach similar to the kinship-based family described by Nieves (1979) was that the choice to "marry" appears to be made by a woman only after becoming convinced that this would be a positive benefit to her and her children (Schmidt, 1985, p. 217).

The Older Woman in the Extended Family

Official statistics that reflect how older persons are incorporated into the extended family system are very limited and, when available, are usually not disaggregated by sex. For example, Myers and Nathanson (1983) used data from selected World Fertility Surveys conducted in the 1970s to examine patterns of household size and composition. Because of problems of definition, their family types are not comparable with those previously discussed. Their analysis is interesting, however, in that they distinguish two types of extended families—those that are "vertically" extended, in which one or more parents live in the household with a couple, and those that are "laterally" extended, in which the extra members are brothers or sisters and their families. In their data on Latin America, the vertically extended families outnumbered the laterally extended ones by a factor of nearly 8 to 1.

Other studies corroborate the continued tradition of families incorporating and sometimes caring for older relatives. Mesfin, Sinha, Jutsum, Simmons, and Eldemire (1987), in a study of elderly in a community near Kingston, Jamaica, report that "the family appeared to be the main support for the older people. Seventy percent lived with their sons, daughters or spouse" (p. 31). On the other hand, 58% of the sample of older persons reported being the head of the household. Thus, although the increasing dependency ratios of older to working age population worries planners (UN, 1985a, p. 192), in many cases the elderly may be at least the titular household heads and not in a dependent position in the family.

One persistent theory about the role of older women in extended families is that they are, by design or by default, caretakers of their grandchildren. Powell (1984) reports that in the Caribbean, the motherhood role carries such status that, when a woman's childbearing years are over, she often voluntarily takes over her daughters' children or even adopts others in order to extend her effective period of motherhood. The first grandchild is considered the highest achievement of "mothering," and confers a rare symbol of status (p. 103). Summaries of official country reports to the World Assembly on Aging held in 1982 corroborate this and indicate that it is a particularly common pattern in rural areas. The primary role of the older woman in the extended family in Guatemala, Jamaica, and Panama was seen as helping with the housework and providing care for the children of working mothers (UN, 1985a, p. 197).

An example of the other extreme of care-giving by default is provided by Chaney (1984), who reports that:

> in the Afro-Caribbean it is not unusual for young women to leave their offspring with their mothers in the countryside when they go to work in the towns and cities of their own islands, or abroad. Sometimes parents never return, leading to a serious problem of abandoned children (p. 101).

Country reports for the World Assembly on Aging from Panama, Trinidad and Tobago, and Jamaica corroborate this assessment, stressing that industrialization and urban living were placing a strain on traditional patterns of family support for the elderly (UN, 1985a).

Cultural differences may make this traditional role of older women less common in other parts of Latin America. Bunster and Chaney (1985), in their study of domestics and street merchants in Lima, found only two cases among the 50 maids interviewed in which child-care problems had been solved by sending the children to live with relatives in the home province. According to these authors, this contradicted the folk wisdom that maids always sent their children home to be raised (p. 143).

Women-headed Households

The extended family household described by Duarte (1988), Nieves (1979), and Myers and Nathanson (1983) is not only likely to include older women, but also to be headed by women. Other types of women-headed households include single women with children, and widows. In the popular sector, a man's place in these households is marginal. According to Nieves (1979), men may belong to and contribute economically to several households; however,

> the principal identification of a man who does not have a conjugal relation is with the household of his mother and sisters, although he may visit one or more women in other residential groups (p. 141).

Thus, an older, widowed woman with sons might expect them to contribute economically to her household, but not to be regular participants there.

The number of female-headed households in Latin America is increasing. Table 27 shows this pattern for nine countries and major cities from 1970 to around 1980. According to the ILO and INSTRAW (1985), factors that contribute to this increase are the growing participation of women in the labor force, increasing migration of men in search of work, and higher levels of marital dissolution. Duarte (1988) also mentioned this last factor, stating that 44% of first marriages in the Dominican Republic fail and that the average number of marriages per person there is 1.4.

Older Women as Heads of Households

In a discussion of cross-national variations in household and family structure, Myers and Nathanson (1983) state that:

> while available cross-national data do not enable us to assess the extent to which older persons reside in households with their children, headship rates indicate that the majority of male older persons continue to maintain their position as heads of households in later life and that female headship in-

Table 27. Households headed by women, as percent of all households, 1970–1980.

Country	Year	% headed by women	Location	Year	% headed by women
Argentina	1970	16.5	Buenos Aires	1982	18.4
Bolivia	1976	26.0	La Paz	—	—
Brazil	1970	13.0	Brazil	1980	18.5
Colombia	—	—	Bogota	1982	19.3
Costa Rica	1973	16.4	San Jose	1982	17.0
Cuba	1970	18.3	Havana	1981	28.2
Mexico	1970	15.3	Mexico City	—	—
Panama	1970	20.6	Panama City	1982	22.9
Peru	1972	22.3	Lima-Callao	1982	18.1
Venezuela	—	—	Caracas	1982	21.0

Source: International Labor Organization, 1986b, p. 50.

creases with age. This is confirmed by analysis of data on marital status, which show higher widowhood levels for females. Marriage at older ages seems to be relatively low (p. 7).

Data from Latin America and the Caribbean confirm the increase in female-headed households with increasing age (Powell, 1984). Table 28 shows the percent of households headed by persons in specific age ranges and the percent of these that are headed by women for urban and some rural settings in selected countries. The differences between urban and rural settings are dramatic. In all households in urban settings, with the exception of Uruguay, by far the largest proportion of heads are in the 10 to 44 year age group and as age increases the proportion decreases. Just the opposite pattern is seen for households headed by women. The percentages of women heads of household start out fairly low in the 10 to 44 year age range (from a low of 8.8 in Brazil to a high of 31.1 in Jamaica

Table 28. Selected household characteristics.

		Urban[a]					
		Percent of all household heads by age groups			Percent of households headed by women by age groups		
Country	Year	10–44	45–59	60 +	10–44	45–59	60 +
Argentina	1980	44.0	31.1	24.9	11.9	19.0	32.4
Uruguay	1975	29.1	31.2	39.7	20.3	21.5	25.2
Venezuela	1981	60.0	26.6	13.4	17.8	27.1	35.6
Brazil	1970	58.9	26.6	14.4	8.8	16.1	24.5
Peru	1972	59.2	24.5	16.4	18.8	24.0	32.6
Panama	1970	56.3	28.6	15.1	22.4	27.4	35.8
Costa Rica	1973	54.3	34.2	11.5	15.5	26.1	36.5
Jamaica	1970	47.0	29.0	24.0	31.1	31.8	41.4
Guyana	1970	53.4	29.4	17.1	16.7	24.7	36.1

		Rural					
		Percent of all household heads by age group			Percent of households headed by women by age group		
Country	Year	10–44	45–59	60 & +	10–44	45–59	60 & +
Uruguay	1975	49.3	33.0	17.7	6.2	9.0	23.8
Venezuela	1981	51.1	28.4	20.5	13.5	19.7	26.2
Panama	1970	54.4	27.7	17.9	10.9	16.8	24.6
Costa Rica	1973	54.7	32.0	10.3	8.4	16.0	23.9

Source: International Data Base, Center for International Research, Bureau of the Census.

[a] Data are for both rural and urban households for Argentina, Brazil, Peru, Jamaica, and Guyana.

with the majority in the teens) and increase steadily until the 60 and over age group. In this age group, only two countries, Brazil and Uruguay, have percentages of women-headed households of less than 30; in Jamaica, the number reaches 41%.

In the four countries for which data are available for rural areas, the pattern is the same. Even in Uruguay, nearly 24% of rural households were headed by women. The only difference is that fewer households overall are headed by women in rural areas. Even so, nearly one-quarter of all households headed by persons 60 and over in the rural areas were headed by women.

Variety of Women-headed Households

Although detailed data on older women in the context of the family are lacking, it is clear that these women play a major role, frequently as household heads. It is also clear that the arrangements they make in the family setting are inextricably bound to the economic strategies used to ensure the survival and, whenever possible, the advancement of family members. A description of one type of arrangement that has both Latin American and Caribbean variations will illustrate these points.

One pattern in Costa Rica is described by Aguilar and Piza (n.d.) as a "Queen Bee Family." It occurs when the children of a single mother grow up, marry, and then are abandoned by their husbands. They return to their mother's home and form a new family in which the grandmother, the children, and the grandchildren live together. The women work outside the home, leaving the grandmother in charge of the children (p. 40).

A similar pattern was described by Bolles (1986) in urban Jamaica. She reported the case of a woman and her two sisters who share a flat near the factory where the woman works. Her preschool daughter is being raised by the child's grandmother in the country until she reaches a "reasoning age"; the woman sends money regularly for her upkeep. The youngest sister attends high school on the early shift and the woman pays for her books and uniforms. In return, the girl starts dinner in the afternoon when she gets home from school. Although her older sister once worked as a casual worker during peak periods at a factory, there has recently been little call for extra help and thus the woman supplies the only income for the three-person household and the care of her daughter in the country (p. 70).

These are only two examples of the myriad ways that families organize themselves in order to maximize their resources. It is clear that midlife and older women play a key role in the maintenance of stable family systems in a large number of cases in Latin America and the Caribbean. The fact that they are often the main source of financial support, however, makes the entire family vulnerable as they age, as we shall see in the following section.

ECONOMIC SECURITY FOR OLDER WOMEN

Few options are available to older women for ensuring their economic security. Sources of support fall into three general categories: the family, continued employment, and national social security programs.

Family Support

Some of the strategies adopted by families have been discussed. It should also be pointed out that government policy makers in many countries are exploring a variety of methods for strengthening the family's ability to include and care for older members. This is partially a pragmatic response to an increasingly urgent problem and partially a result of cultural values that still designate the extended family as the appropriate caretakers for frail or aging relatives. Among the proposals for assistance are financial subsidies to caretaker families, multigenerational housing design, promotion of "foster families," community-based social services such as daycare and senior centers, and educational programs to motivate young people to care for older family members (UN, 1985b, p. 196).

Continued Employment

Continued employment is obviously only a temporary solution to the problem of economic security for older women. Contreras de Lehr (1986, p. 69) points out that, failing other sources of support, many older persons—male and female—simply continue to work until their health no longer permits it, particularly in rural areas. The UN report on the *World Aging Situation* (1985b) echoes this opinion (p. 197), but neither source provides data or speculates about what happens to older workers when their energy finally gives out.

Again, the high costs of national assistance programs has caused policy makers to look for ways to promote older persons' continued participation in remunerated economic activity. A major strategy being proposed is to provide training in income-generating skills through continuing and refresher courses held at senior centers and elsewhere. A target group for this type of training is housewives seeking employment (UN, 1985b, p. 194). Other ideas include delayed retirement, flexible scheduling, retraining to match changed physical abilities as workers age, establishing job banks, and creating inventories of occupations that could be filled by the aging. Mandatory retirement ages have also come under scrutiny, and proposals have been made either to raise these, since they were established when life expectancy was lower, or to make their application more flexible. Finally, legislation has been proposed to eliminate age barriers to employment and discrimination in the labor market.

A major difficulty in trying to enhance the elderly's economic security by facilitating their continued employment is that these efforts often are perceived to be in direct opposition to programs designed to provide employment for youth. Jamaica's national report to the World Assembly on Aging in 1982 questioned the ability of the government to respond to the simultaneous demands of the young and the older workers in the face of high overall unemployment levels (UN, 1985b, p. 195).

Clearly, the majority of the proposed responses to economic security problems of the aged that involve continued employment are not designed with women in mind. It is men who compose the large majority of the economically active population in the formal sector at all ages, and we have seen that women's participation, particularly after age 60, drops precipitously. When choices for employment must be made between men and women and between the young and old, older women are quite likely to fall to the bottom of the priority list. One does not even have to assume discriminatory practices to find reasons for this. Older women have less education and fewer skills to begin with. They are less likely to have held formal sector employment before and thus would require not only extensive training but considerable orientation to move into salaried employment on anything but a very low level. The investment is not cost-efficient, even if funding were available, and in most cases it is not.

National Social Security Plans

Particularly for women in late midlife and older who have not done remunerated work previously, other solutions must be found to assure economic survival. When other possibilities have been exhausted, income-tested social welfare programs become a last-resort resource (Eldemire, 1988; Brathwaite, 1988). In the Latin American region, older women living alone and poor urban elderly (also mostly women) are the primary targets for services (UN, 1985b, p. 202).

At the same time, it is generally recognized that there are no reliable statistical data on the health, social, and economic needs of older persons in the Region on which to base program plans (UN, 1985b, p. 202). As a result, official programs have developed in response to immediate needs and have varied vastly among countries in the Region. Despite the specific targeting of women, data about the programs and services offered are not disaggregated by sex, except in the case of occasional country studies. Before the available information on women is reviewed, an understanding of the general status of social security programs in Latin America would be helpful.

The Nature and Status of Latin American Social Security Programs

In a landmark article comparing social security programs in 20 Latin American countries (excluding the English-speaking Caribbean), Mesa-Lago (1986) has ranked these countries on the basis of 11 factors indicating their system's level of development. His table has been partially reproduced as Tables 29 through 31 to compare aspects of the systems among the countries in relation to levels of coverage and cost to the country of maintaining it.

Most social security systems include both health benefits and various forms of pension and income assistance. Cash benefits may take the form of contributory pensions, or may involve income assistance to those in need. Health benefits range from free (but usually inadequate) public health programs to various forms of private or public insurance. In almost all cases, coverage depends on the employment of one or more family members (UN, 1985b; Mesa-Lago, 1986). This implies that those who have never been part of the "official" employment schemes (public or private) in a country would not qualify for benefits. Thus, although in theory, benefits are available to men and women equally, it is well to keep in mind that the lack of an employment history serves to exclude a great many older women from any benefits under these systems.

Mesa-Lago divided the countries into three groups and has described typical patterns in each one. The upper group in Tables 29 through 31 began their pension programs in the 1920s: coverage of some kind is nearly universal when noncontributory assistance to the poor is included; the contribution rate is over one-fourth of earnings, and social security expenditures make up nearly one-third of the national budget, with half being spent on pensions as a result of increased life expectancy; the pensioner/contributor (dependency) ratio is very high, 0.6 in one case, indi-

Table 29. Percent of total population and economically active population covered by social security and contribution rates by development groups.

Group/countries	Population covered[a]		Statutory contribution rate[b]
	Total	Economically active	
Upper group			
Uruguay[c]	69	81	33
Argentina	79	69	46
Chile	67	62	29
Cuba[c]	100	93	10
Brazil	96	96	26
Costa Rica	78	68	27
Intermediate group			
Panama	50	46	21
Mexico	53	42	18
Peru	17	37	21
Colombia[d]	12	22	20
Bolivia	25	18	25
Ecuador	8	23	21
Paraguay	18	14	20
Venezuela	45	50	14
Lower group			
Dominican Republic	8	14	14
Guatemala[c]	14	33	20
El Salvador	6	12	12
Nicaragua	9	19	16
Honduras[e]	7	13	14
Haiti	1	2	12

Source: Adapted from Mesa-Lago, 1986, pp. 128–129.

[a] Percentage of the total population covered by the sickness program, and of economically active population covered by pension programs.

[b] Total statutory percentage of payroll to be contributed by the insured person, the employer, and the State.

[c] Some figures are for 1981 instead of 1980.

[d] 1979.

[e] 1982.

cating that fewer than two workers support one pensioner. Countries in this category will face serious problems in funding their systems and will have little capacity for expansion.

In the intermediate range countries, pension programs began in the 1930s or 1940s: coverage ranges from 18% to 52% of the population, and the contribution rate is approximately 29% of earnings; expenditures are around 3% of the gross domestic product, and constitute between 14% and 23% of the national budget. In these countries, most of this is spent on health programs because of the young population and lower life expec-

Table 30. Social security expenditures as a percentage of gross domestic product, national budget, and pensions by social security groups.

	Social Security expenditure as a percentage of:[a]		
Group/countries	Gross Domestic Product	National budget	Pensions
Upper group			
Uruguay[b]	11	38	79
Argentina	10	38	55
Chile	9	32	53
Cuba[b]	9	13	44
Brazil	5	38	45
Costa Rica	9	36	21
Intermediate group			
Panama	7	23	34
Mexico	3	10	21
Peru	3	15	35
Colombia[c]	4	20	20
Bolivia	3	14	40
Ecuador	3	18	48
Paraguay	2	22	31
Venezuela	3	15	33
Lower group			
Dominican Republic	2	16	21
Guatemala[b]	2	14	14
El Salvador	2	12	18
Nicaragua	2	13	16
Honduras[c]	3	12	7
Haiti	1	na	10

Source: Adapted from Mesa-Lago, 1986, pp. 128–129.

[a] Social Security expenditures includes total health expenditures.

[b] Some figures are for 1981 instead of 1980.

[c] 1979.

tancy. Only between 20% to 40% is spent on pensions. Although money is available to fund pensions, the systems are in financial imbalance and will have deficits in the future.

Countries in the lower range began pension programs in the 1950s and 1960s, and coverage of the population is limited to about 10% of the total population and 19% of the economically active population. Most services and pensioners are in the capitals and largest cities. Contributions from earnings are only between 12% and 16%, and social security accounts for only about 2% of the gross domestic product and less than 18% of the national budget. About 80% of the revenues are spent on

Table 31. Ratio of pensioners to contributors, percent population 65 & older, and life expectancy at birth by social security groupings.

Group/countries	Ratio: pensioners to contributors[a]	Population 65 & over	Life expectancy at birth
Upper group			
Uruguay[b]	0.65	10.4	70
Argentina	0.32	8.2	69
Chile	0.46	5.5	68
Cuba[b]	0.21	7.3	73
Brazil	0.18	4.0	64
Costa Rica	0.06	3.2	71
Intermediate group			
Panama	0.12	4.4	70
Mexico	0.08	3.6	64
Peru	0.09	3.6	58
Colombia[c]	0.05	3.5	62
Bolivia	0.33	3.2	51
Ecuador	0.15	3.5	60
Paraguay	0.07	3.4	64
Venezuela	0.06	2.8	66
Lower group			
Dominican Republic	na	2.9	60
Guatemala[b]	0.06	2.9	58
El Salvador	0.08	3.4	62
Nicaragua	0.08	2.4	55
Honduras[d]	0.02	2.7	57
Haiti	na	3.5	51

Source: Adapted from Mesa-Lago, 1986, pp. 128–129.

[a] Dependency ratio: number of pensioners/number of contributors.

[b] Some figures are for 1981 instead of 1980.

[c] 1979.

[d] 1982.

health programs, and less than 20% on pensions. Since the pensioner/contributor ratio is very low (0.02 to 0.08) there is a surplus of money for pensions and there is an ability currently to extend coverage without financial imbalance occurring in the short to medium range (Mesa-Lago, 1986, pp. 132–133).

Types of Coverage

The systems have evolved with industrialization and are closely linked to economic activity. The first risks covered were those of work accidents and occupational diseases. These were followed by benefits for sickness, other accidents, and maternity. Maternity benefits were at first provided only for female salaried workers, then later extended to wives or common-law wives of male workers. Next to be added were old-age and disability pensions and, somewhat later, pensions for survivors. At the beginning of the 1980s all 20 countries included all these programs, although coverage was variable and extremely limited in the lower and low-intermediate countries.

The last programs to be introduced were family allowances and unemployment benefits based on past employment. As of 1982 these were in place in less than 10 countries. Mesa-Lago also notes that priority has been given to extending coverage to more risks (vertical extension) rather than to more people (horizontal extension). This produces a situation in which "quite often a minority of the population is covered against all risks, but the majority is not protected against any risk at all" (Mesa-Lago, 1986, p. 134).

A related problem has to do with whether coverage is statutory, prescribed by law, or statistical, actually in effect. Statutory coverage is highest for sickness and maternity benefits. However, coverage is greatest for urban wage earners and their dependents, and in many cases nonexistent for agricultural workers, the self-employed, and those in domestic service, as well as the dependents of persons in all of these categories. Additionally, in a quarter of the countries coverage is limited to the capital and larger cities.

Statistical coverage information is unreliable for a number of reasons, including a large number of administering institutions, methods of estimation, and selective reporting of risks covered. Figures for the economically active population are generally more reliable. Mesa-Lago (1986, p. 136) has reported the most accurate statistics available. These indicate that: coverage is generally better in the more highly developed countries; and in the Region as a whole, certain countries are greatly overrepresented in the distribution of coverage. Thus, of all persons covered by both health and economic programs, three countries account for over 80% of the coverage: Brazil, 54%, Mexico, 17%, and Argentina, 10%. When the health and economic aspects are considered separately for pension programs for the economically active population, the percent coverage is 75% to 100% in Cuba, Brazil, and Uruguay; 50% to 74% in Argentina, Costa Rica, Chile, and Venezuela; 25% to 49% in Panama, Mexico, Peru, and Guatemala; and 1% to 24% in Ecuador, Colombia, Nicaragua, Bolivia, Honduras, Paraguay, the Dominican Republic, El Salvador, and Haiti.

There are differences in coverage when health programs are examined. The countries' percent of coverage through public or private sources are as follows: 75% to 100% in Cuba, Brazil, Argentina, and Costa Rica;

50% to 74% in Uruguay, Chile, Mexico, and Panama; 25% to 49% in Venezuela and Bolivia; and 1% to 24% in Paraguay, Peru, Guatemala, Colombia, Nicaragua, Ecuador, the Dominican Republic, Honduras, El Salvador, and Haiti. It is clear that in the case of health programs, the Region's countries group at the upper and lower extremes of coverage (Mesa-Lago, 1986, pp. 136–137).

In Latin America, overall social security coverage, including both economic and health risks, is said to stand at about 60% of the population. If Brazil is excluded from this estimate, however, then the rate drops to less than 43%. In more than half the countries, less than 25% of the population is covered.

Inequities of Coverage

It is virtually impossible to estimate the actual amount of coverage that women at midlife and older have. If we consider only the salaried employed on which all countries base their social security systems, then approximately 20% of women at midlife and older might have statutory coverage. In some countries, women in these age groups possibly may be covered as dependents under the entitlement of their husband or common-law spouse. Officially, all countries have old-age, disability, and survivor's benefits; seven have family allowances; and five, unemployment programs as well. Tibaudin (1987), in a discussion of the problems of women's pensions, calls these extended benefits "hardly developed" in the Americas, and feels women are almost entirely deprived of this type of assistance.

In the eight countries where coverage of the entire population exceeds 50%, chances are that at least some urban dwelling women would qualify for certain programs. But in Haiti, where coverage of the economically active population is estimated at 1.6%, government programs provide no answer.

Legally, in all countries in the Region, men and women have equal rights to social security benefits. However, structural and other inequities disproportionately affect women. In many countries where vertical extension of benefits has been common, coverage tends to be positively correlated with income, skill required for the job, and power of pressure groups. The lowest coverage is found among the unskilled, agricultural, and self-employed workers, as well as the unemployed and the lowest-income groups. As Mesa-Lago points out, "the most needy groups appear to be deprived of social security protection in the great majority of the countries" (1986, p. 138). Older women certainly would qualify as one of these groups.

In most of the Region's countries, the retirement age for women—usually 55 years of age—is at least five years younger than for men. Although at first this seems an advantage, frequently pensions are based on length of participation in the work force and qualifying periods apply (International Social Security Association [ISSA], 1982). Given the often part-time and seasonal nature of women's employment, this puts them at considerable disadvantage.

Costs of social security programs are growing steadily. At the same time the economic crisis and inflation of the early 1980s are increasing the need for services and decreasing the countries' ability to respond. Mesa-Lago sees little hope for change in the near future. In response to the crisis, countries in the Region have tried to institute reforms. At the same time, however, they have occasionally delayed processing claims for two to three years, and have cut back on health service, a benefit disproportionately used by women.

Case Studies of Countries that Provide Social Security Coverage for Older Women

Costa Rica

In 1984 a major study of the needs of the elderly was undertaken in Costa Rica. A stratified random sample of 1,155 persons over 60 in both urban and rural areas answered an 80-item questionnaire. Raabe's (1987) report describes the sample as having 502 (43.5%) males and 653 (56.5%) females, distributed nearly equally in five-year age groupings from age 60 to age 85 and over. The urban-rural distribution of the sample members followed the distribution reported in earlier sections: 64% of the women and 54% of the men were from urban areas; 36% of the women and 46% of the men were from rural areas. Seventy-two percent of the men were married, as were 46% of the women. There were 32% of the women and 11% of the men who were widowed.

The respondents were asked if they felt the need to work for economic reasons. Forty-eight percent of the men and 21% of the women answered affirmatively. Raabe calls attention to the fact that although 21% of women 60 and over felt the need to work, only 8.1% reported that they either worked or were looking for work. Thus, 12% of older women felt economic pressure although, for whatever reason, they were not currently looking for employment.

Pensions were available to 45% of the men but only to 30% of the women in the study. The proportion of both sexes who had pensions increased with age, so that at ages 60 to 64, 26% of the men and 18% of the women had pensions; for those aged 75 and older, 56% of the men and 44% of the women had pensions. There were urban-rural differences in the proportions having pensions, with a higher proportion covered in urban areas. This difference was less for women (30% versus 28%) than for men (49% versus 41%).

Among those who received pensions, the most common type was noncontributory family assistance; over half of the women and a third of the men received this type. The remaining two-thirds of the men were covered by contributory pensions relating to age, years of service, and disability, while about a quarter of the women reported this type of coverage. The remaining women were receiving benefits as widows or survivors. No men reported this source of pension funds (Raabe, 1987, pp. 39–40).

In evaluating these figures it is well to keep in mind that the women covered represented less than one-third of those sampled, in a country which ranks sixth in the Region in development of its social security system according to Mesa-Lago's factor system (Mesa-Lago, 1986, p. 128). Given that the most common type of pension was noncontributory family assistance, these women were probably among the more fortunate in the Region. In many of the other countries, this type of help would not be available at all.

Dominican Republic

Although the information is not disaggregated by sex, in the Dominican Republic—which Mesa-Lago (1986) ranks fifteenth in social security—Duarte (1988, p. 1) reports that the social security system protects only 4% of the total population of the country, 11.5% of the economically active population, and 22% of salaried employees.

Mexico

In a discussion of aging in Mexico, Contreras de Lehr (1986) points out that population aging is a relatively recent phenomenon in her country. Because the majority of older women have devoted themselves to unremunerated household labor, they find themselves lacking in social security and thus in a particularly precarious position.

Although we can assume that women are making some progress in gaining social security coverage by virtue of increasing employment rates, Contreras de Lehr's (1986) evaluation of the situation of Mexican women *currently* at midlife and older is probably true for most of Latin America. The lack of factual information in this area is a serious handicap in making recommendations for improvements.

English-speaking Caribbean

A somewhat different system of social security operates in the more developed islands of the Caribbean. Eldemire (1988) notes that in Jamaica there are nearly 500 Superannuation Funds/ Pension Schemes/ Provident Funds operating. Their assets, however, are also derived from employees and employers and from the investment of these funds. Private insurance became available after independence in 1962, but most of the elderly are not eligible for these. The compulsory national insurance program provides old-age and survivor's benefits *if* the person was employed. A statutory program of relief to the poor and a food security program are also available to applicants who qualify on the basis of a means test. A food-stamp card issued to beneficiaries also entitles them to free health care at clinics and hospitals. Coverage for the contributory programs was nearly 44,000 in 1984, and approximately 21,000 in the poor/relief program. In the poor/relief program, most recipients were over 60 years old and about 2,000 were institutionalized (pp. 13–17).

Brathwaite's (1988) study of the elderly in Barbados presents a small amount of information about social security which was not disaggregated by sex. Of his sample of 525 persons aged 65 and over, 76% reported their source of income as pensions of unspecified types (p. 8). Nearly 85% were retired, and of these 75% were compulsorily retired. One-third were not happy with this situation and just under half (48.6%) reported that financial difficulty was the main disadvantage of retirement.

Eldemire (1988) in Jamaica and Brathwaite (1988) in Barbados reported a wide range of health, social, educational, and recreational programs available to older persons through both government and private or church-run sources. Although it is not possible to generalize to the entire English-speaking Caribbean, in these two countries at least, it seems that a heightened awareness exists of the needs of a predominantly female elderly population.

HEALTH STATUS

The use of the word "health" in the narrow, medical sense is not useful in the context of this report. In a very real sense, the well-being of midlife and older women in Latin America is a product of everything that has been previously discussed, and more. Factors such as urban-rural residence, marital status, numbers of children born and living, educational level, income through employment or by virtue of marriage, nutrition, integration in a functional family setting, and provision for financial independence and medical services in old age interact in complex and only partially understood ways. The result is a relative state of well-being that is much more than simply the presence or absence of illness. It is, in fact, a *gestalt* that will be described here (for lack of a better word) as quality of life.

Other factors which have not yet been discussed contribute to quality of life as well. Physical environment has not come under much scrutiny, but work and living conditions may have a tremendous influence on physical and mental health. Psychological well-being that derives from basic personality traits will cause individuals to react very differently to the same challenges. The presence or absence of various risk factors, either genetic or life-style related, plays a major role. Finally, specific diseases and conditions that ultimately cause illness and death must be taken into consideration.

Mortality and Its Causes Among Midlife and Older Women

In order to continue the discussion within the framework initially established, the last of these new factors—diseases and conditions that cause death—will be considered first. Available information for the English-speaking Caribbean will be included in this section.

Table 32 displays median age-specific death rates for women in selected age groups, by country group, and for selected Caribbean countries. Although age- and sex-specific mortality rates are valuable indicators, particularly when a certain part of the life span is the focus of interest, they are only as good as the recording of population and mortality statistics in the countries providing the data. Information in Tables 32 to 36 is derived from sources prepared by PAHO from data obtained from member countries. In some cases, UN population data and their adjustment techniques were used when the quality of the data required this (PAHO, 1986a). Table 32 also includes age-specific death rates for the United States in order to provide a frame of reference.

The Region's death-rate information is not disaggregated for urban and rural residence. However, rates for the highly urban and highly rural country types serve as an indication of the situation in urban and rural

Table 32. Median age-specific death rates for women in selected age groups by country types; the Caribbean and the USA.[a]

	Age			
Country type	35–44	45–54	55–64	65–74
Highly urban	1.8	4.5	9.3	24.0
Mixed	2.2	3.5	8.6	22.7
Highly rural	3.1	5.3	10.3	25.8
Caribbean	2.3	5.4	12.0	26.7
(USA)	(1.4)	(3.9)	(9.2)	(20.9)

Source: Pan American Health Organization, 1984, p. 237.

[a] Caribbean countries for which data were available include: Bahamas, Barbados, Belize, Guyana, Martinique, Netherlands Antilles, St. Lucia, Suriname, Trinidad and Tobago, and Virgin Islands (US).

areas. For all the reasons cited previously, i.e., better education, improved opportunities for employment, fewer children to bear and care for, as well as better access to health services and medical care, one would expect the death rates to be lower for all ages in the more urban countries than in the more rural ones. This hypothesis is borne out in all four of the age cohorts examined.

This is the only clear pattern that emerges, however. Mixed and Caribbean countries have rates similar to both urban and rural countries, depending on the age cohort under examination. None of the patterns resemble that of the United States.

In an effort to clarify the situation, male and female rates were compared by calculating the ratio of male/female mortality rates. Table 32 and Figure 5 show these relationships using median male deaths per 100 female deaths with the same age groups as those used for age-specific death rates.

In Figure 5 it can be seen that each country type, the Caribbean, and the United States each show a different pattern. The only consistency is that in all cases and for all ages beginning at age 35, death rates for men exceed those for women.

The trends over the 40-year age range, however, are very different for each set of countries. The curve seen in the highly urban countries is produced by a death rate for males in the middle two decades which nearly doubled that of females. In the mixed countries and the Caribbean countries, there is a downward trend in the ratios, indicating decreasing differences in age-specific death rates for men and women as they age.

In the rural countries and the United States, the pattern is similar and relatively stable across the age groups. The difference between the two is that the ratios are consistently lower in the rural countries than in the

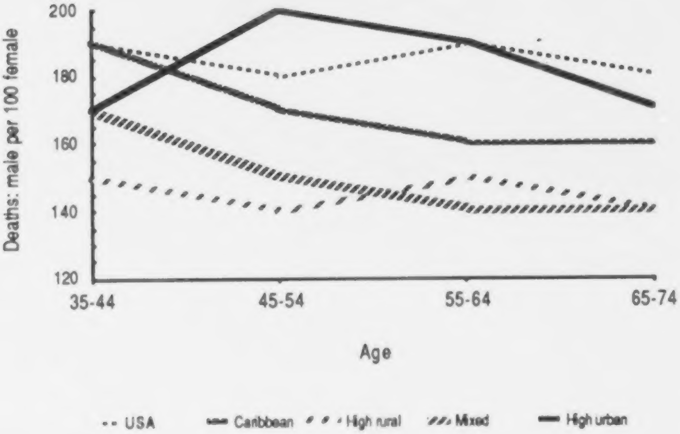

Figure 5. Median number of male deaths per 100 female deaths in selected age groups and areas.

United States, indicating more equal age-specific death rates across the life span in the rural countries. In the United States, the ratios are stable at a much higher level, indicating that the age-specific death rates for men in these age groups is almost double that of women.

Similar patterns have been noted by other authors in relation to high and low mortality countries (PAHO, 1985a). Ruzicka and Lopez (1983, p. 478) describe an admittedly oversimplified process by which there are two broad groups of causes of sex differentials in death rates that interact in different ways at different levels of development of countries: the first is genetic-biological and environmental; the second, social, economic, and cultural. The authors suggest that in high mortality countries, environmental disadvantages may outweigh any biological advantage enjoyed by women, so that factors such as high maternal mortality from malnutrition and poor access to prenatal and childbirth care may cause a gap in the life expectancy at birth by as much as three to four years in favor of males.

With reduction in mortality through improved sanitation and other public health measures, and through better nutrition, education, health care, and standard of living, the environmental disadvantages may be reduced and the genetic-biological factors allowed to advance female longevity, eventually to a point at which life expectancy surpasses that of males. This gap, at this point in favor of females, may be further increased by social and life-style risk factors that cause additional male mortality. These factors include such things as occupational health hazards, motor vehicle accidents, violence, and the abuse of alcohol and cigarettes. The low mortality countries correspond with the highly urban categorization used in this report. The curve noted in Figure 5 in these countries may be partially explained by the additional male mortality described by Ruzicka and Lopez (1983).

The Effect of Age

It must be recalled that the process described by Ruzicka and Lopez takes into account the entire life span, while the patterns of male/female mortality ratios illustrated in Figure 5 consider only age groups beginning at 35 years. With one exception, among the less developed countries studied by the UN Population Division (1983, p. 30), "The largest contribution to the female advantage in life expectancy has come from ages 45 and over." Thus, it is in the second half of the life span that one sees the greatest differences in mortality rates between men and women. Even so, as Figure 5 shows, the pattern of these differences changes with aging in different ways in different types of countries.

The rural countries, with their relatively low and stable ratios, resemble the high mortality countries of Ruzicka and Lopez (1983), in which the female biological advantage is diminished by higher maternal mortality, poor nutrition, education, etc. The urban countries resemble the low mortality countries in which improved maternal health and excess male risk from environmental and life-style factors give women a decided advantage in terms of mortality.

The mixed and Caribbean countries probably represent an intermediate or transitional stage in this process. The interesting point is that as age increases, the differences between male and female mortality decrease. One could speculate that in transitional situations those who survive to advanced ages display a biological advantage that may be independent of gender. This is further illustrated by the fact that no matter what the patterns have been in earlier parts of the life span, male-female mortality ratios level out at advanced ages and gender-free biological factors take over.

The pattern for the United States, which so closely resembles that of the rural countries, is a classic reversal. The advantage of the rural (high mortality) countries is clearly male, while that of the urban (low mortality) countries is clearly female, yet the trend of their mortality rates is parallel.

Causes of Death

The *reasons* for mortality among women at midlife and older, for two age groups (45-64 years and over 65 years), by country types in Latin America and for the Caribbean separately, are presented in Tables 33 through 37. Again, it must be kept in mind that this information is dependent on the accuracy of reporting in each country. In this case, not only must the death be reported, but the cause as well. Thus, nuances of diagnosis are inevitable, and comparability may be compromised. Data for the Tables came from the PAHO (1986a) publication, *Health Conditions in the Americas, 1981-1984*. This source contains the most current information and lists the five leading causes of death in each country for which data are available; in some cases, ties are reported. Approximately 10 causes account for most of the mortality among the women of these age groups in Latin America. Somewhat different conditions, but an equal number of major killers, are responsible for most deaths in the Caribbean.

Table 33 shows the five major causes of death for women aged 45-64 in Latin America in the 1980s. Malignant neoplasms are the leading cause of death in most countries, with heart disease rating as second. Cerebrovascular disease, diabetes, and accidents follow in the majority of cases. It is interesting that in three countries, ranked toward the more urban end of the urban-rural continuum, chronic liver disease (often the result of alcohol abuse) is a major cause of death. Among the countries ranked toward the rural end of the continuum, infectious processes such as influenza, pneumonia, and intestinal infections assume greater importance, along with nutritional deficiency. This suggests that urban stresses may often result in life-style-related responses such as substance abuse, even among older women, while in the rural countries, major causes of death are still likely to be related to lack of basic environmental and preventive services.

The pattern is even more prominent in the older age group. Table 34 shows that, although influenza and pneumonia assume more importance in all countries, nutritional deficiencies, intestinal infections, and other respiratory infections are concentrated among countries at the rural end of the spectrum.

Heart disease becomes the major cause of death with cerebrovascular

Table 33. Five leading causes of death for females age 45 to 64 in Latin America, 1980s.

		Causes					
Country type	Country	Diseases of the heart	Cerebro-vascular disease	Malignant neoplasms	Diabetes mellitus	Accidents	Other (rank)
Highly urban	Argentina	2	3	1	5	4	
	Uruguay	2	3	1	4	5	
	Chile	2	3	1	—	—	Chronic liver disease (4)
	Venezuela	2	3	1	4	5	
	Cuba	2	3	1	5	4	
Mixed	Puerto Rico	1	4	2	3	—	Chronic liver disease (5)
	Brazil[a]	1	3	2	4	—	
	Mexico	2	4	1	3	5	
	Colombia	2	3	1	5	4	
	Peru	2	5	1	—	—	Flu and pneumonia (3); tuberculosis (4)
	Dominican Rep.	1	3	2	5	—	Chronic liver disease (4)
	Panama	2	3	1	4 (tie)	4 (tie)	Flu and pneumonia (5)
	Costa Rica	2	3	1	4	—	Bronchitis, emphysema, asthma (5)
Highly rural	El Salvador	2	3	1	5	4	
	Ecuador	2	3	1	—	4	
	Paraguay	2	3	1	4	5	
	Guatemala	3	—	1	—	—	Intestinal infections (2) Flu and pneumonia (5); nutrition (5)
	Honduras	1	3	2	—	4	Intestinal infections (2)

Source: Pan American Health Organization, 1986a, pp. 356-368.

[a] Ages are 50-64.

[b] Ages are from 45-59.

Table 34. Five leading causes of death for females age 65 and over in Latin America, 1980s.

		Causes					
Country type	Country	Diseases of the heart	Cerebro-vascular disease	Malignant neoplasms	Diabetes mellitus	Influenza/ pneumonia	Other (rank)
Highly urban	Argentina	1	2	3	4	5	
	Uruguay	1	3	2	4	5	
	Chile	1	2	3	5	4	
	Venezuela	1	2	3	5	4	
	Cuba	1	2	3	—	4	Accidents (5)
Mixed	Puerto Rico	1	2	3	4	5	
	Brazil	1	2	3	4	5	
	Mexico	1	2	3	4	5	
	Colombia	1	2	3	4	5	
	Peru	1	3	4	—	2	Tuberculosis (5)
	Dominican Rep.	1	3	2	4	5	
	Panama	1	3	2	4	—	Accidents (5)
	Costa Rica	1	2	3	4	4	
Highly rural	El Salvador	1	3	2	—	4	Accidents (5)
	Ecuador	1	2	3	—	4	Accidents (5)
	Paraguay	1	3	2	5	4	
	Guatemala	1	4	—	—	2	Intestinal infections (3) Nutritional deficiencies (5)
	Honduras	1	2	3	—	—	Intestinal infections (4) Bronchitis, emphysema, asthma (5)

Source: Pan American Health Organization, 1986a, pp. 356-368.

disease coming in second. Malignancies have fallen to third place, followed by diabetes, and influenza and pneumonia.

In Tables 35 and 36, similar patterns can be observed among older women in the Caribbean. Chronic liver disease, however, appears to be a much greater problem in the Caribbean among the 45 to 64 year-old women than in Latin America, with half of the countries reporting it as the fourth or fifth leading cause of death. This is a puzzling finding, since neither the PAHO publication from which the Table was developed, nor any other references consulted mention either alcoholism or chronic hepatitis as major problems of older women (PAHO, 1985a; Scott, 1988). PAHO (1985a) reports that alcoholism rates are higher among men, but mentions the possibility of increasing drug abuse among (presumably young) women with repercussions for future generations (p. 152). PAHO (1986a) also reports that hepatitis B, which may cause chronic hepatitis and cirrhosis, is found among adults on some of the smaller Caribbean islands and is probably endemic on the larger ones, but that the death rates from cirrhosis do not correlate with the prevalence rates of hepatitis B in the Latin American Region (p. 110). We hope that research in progress will shed some light on this subject.

A cause of death common in the Caribbean at both younger (45-64) and older ages (65 and over) that is also confusing is "mental disorder," which ranks fourth or fifth five times in the two Tables. The reasons for citing this cause are clearer, since senility is frequently listed as a cause of death among the elderly (PAHO, 1986c, p. 29), and hospital discharge diagnoses showed dementia and psychosis among the top five in an epidemiological study in Barbados (PAHO, 1986a, p. 94; Brathwaite, 1988, p. 19).

Cancer

Beginning at about age 35 and continuing through midlife and beyond, malignancies rank first or second as causes of death. Among these, two types of cancer—breast and uterine cervix—are by far the greatest killers. Level of development is highly correlated with the prevalence of these two types. In the less developed and more highly rural countries, cancer of the cervix predominates. Within these countries, this problem is more common among the poor, among those who initiated sexual activity early, and those who have had multiple sexual partners (PAHO, 1985a; PAHO, 1986a; Restrepo, 1983).

Recently it has been noted that the risk to women may also depend on the number of previous sexual partners of her husband, giving rise to

Table 35. Five leading causes of death for females age 45–64 in the Caribbean, 1980s.

Country	Causes					
	Diseases of the heart	Cerebro-vascular disease	Malignant neoplasms	Diabetes mellitus	Accidents	Other (rank)
Bahamas	2	3	1	—	5	Chronic liver disease (4)
Barbados	2	3	1	—	5	Chronic liver disease (4)
Belize	1	2	3	4	—	Influenza (5) tie; Meningitis (5) tie; Tuberculosis (5) tie
Guyana	2	1	4	—	—	Benign neoplasms, carcinoma in situ (3); Mental disorders (5)
Martinique	2	3	1	—	—	Chronic liver disease (4); Mental disorders (5)
Netherlands Antilles	1(tie)	2	1 (tie)	3	5 (tie)	Bronchitis, emphysema, asthma (4); Nephritis (5) tie
St. Lucia	1	4	2	3	—	Nephritis (5)
Suriname	1	3	2	—	5	Chronic liver disease (4)
Trinidad and Tobago	1	4	2	3	—	Chronic liver disease (5)
Virgin Islands	3	2	—	—	3 (tie)	Homicide (3) tie; Mental disorder (3) tie

Source: Pan American Health Organization, 1986a, pp. 348–355.

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Table 36. Five leading causes of death for females age 65 and over in the Caribbean, 1980s.

Country	Causes: Diseases of the heart	Cerebro-vascular disease	Malignant neoplasms	Diabetes mellitus	Influenza	Other (rank)
Bahamas	1	2	3	—	4	Mental disorder (5)
Barbados	1	2	3	4	5	
Belize	1	3	2	5	4	
Guyana	1	2	4	—	—	Nonmalignant neoplasms, carcinoma in situ (3); Accidents (5)
Martinique	1	2	3	4	—	Mental disorder (5)
Netherlands Antilles	1	3	2	5	4	
St. Lucia	1	2	4	3	5	
Suriname	1	2	3	—	5	Bronchitis, emphysema, asthma (4)
Trinidad and Tobago	1	2	4	3	5	
Virgin Islands	1	2	3 (tie)	—	—	Accidents (3) tie

Source: Pan American Health Organization, 1986a, pp. 356-364.

speculation that cervical cancer may be, at least in part, a sexually transmitted disease (PAHO, 1985a, p. 138; Zunzunegui, King, Goria, and Charlet, 1986). Not only is cervical cancer the major cause of death among malignancies, but its prevalence appears to be on the rise. A study conducted in Mexico, for example, showed that between 1974 and 1981, the death rate from cervical cancer increased from 22 to 33 per 100,000 (Espinosa, 1986, p. 100). In the areas of greatest risk this can reach a rate of 151 per 100,000 (Bolivia) and 149 per 100,000 (Panama) (Restrepo, 1983, p. 89).

In more developed countries and among older women, breast cancer is more common. In Latin America, breast cancer deaths exceed those from cervical cancer in Argentina, Cuba, and Uruguay (Restrepo, 1983, p. 91; PAHO, 1985a, p. 136). This difference is due, first, to the fact that periodic, regular vaginal cytology tests (Pap smears) have been available for 25 years to facilitate control of cervical cancer. This type of preventive activity is more common in urban areas and among better educated, higher status women (PAHO, 1985a, p. 138). Second, family history and high fat diet are considered risk factors for breast cancer as well. At least the latter of these is likely to be more common among higher status women.

Table 37 illustrates these patterns. The differences are particularly striking in the highly urban countries, where deaths from breast cancer clearly predominate; in mixed countries there is little difference, while in highly rural countries cervical cancer takes precedence. Information from Caribbean countries is not included because of small sample size. However, these countries generally follow the same patterns: those more highly developed, such as the Bahamas, have rates similar to the highly

Table 37. Median age-adjusted death rates per 100,000 women for breast and cervical cancer by country type.

	Type of malignancy	
Country type	Breast	Cervical
Highly urban	4.3	1.7
Mixed[a]	2.0	2.3
Highly rural[b]	0.9	1.6

Source: Pan American Health Organization, 1986a. Adapted from Annex III-3, pp. 203–231.

[a] Data were unavailable for Brazil, Colombia, and Nicaragua.

[b] Data were unavailable for Bolivia and Paraguay.

urban countries (8.8 for breast and 1.3 for cervical cancer); those less developed, such as Suriname, more closely resemble the highly rural countries with rates of 3.1 for breast and 8.6 for cervical cancer.

It is rare to find patterns this clear-cut and consistent. It would seem that this is one case in which enough is known about a major cause of death so that intervention could proceed. Indeed, both PAHO and other groups have begun major educational efforts to alert women to the risk factors associated with these two forms of cancer and the treatments available. Unfortunately, access to screening examinations—such as Pap smears and mammograms—that would facilitate early diagnosis and treatment is difficult to provide and expensive to implement, and changes in risk behavior that might prevent the conditions will come too late for most women currently at midlife and beyond. Nonetheless, this is one area in which hope exists for reducing deaths from these causes in the future.

Cardiovascular and Cerebrovascular Diseases

Among women 65 years of age and older, these two causes of death rank number one and two in both Latin America and the Caribbean. In some respects, this can be considered an indicator of improved health for the Region as a whole, since these causes of death are associated with increases in longevity and levels of development (Tenias de Salazar, 1985, p. 73; PAHO, 1986a). Despite the high rankings of these conditions among older women, death rates from cardiovascular problems are still higher among men, particularly in the more urban countries (PAHO, 1985a, p. 114). Trends over time are difficult to discern. A study of changes in age-adjusted death rates from cardiovascular disease from 1968 to 1978 showed patterns similar for men and women (PAHO, 1985a, p. 121). In some countries with the highest urban concentrations of older women, e.g., Argentina, Chile, Colombia, Costa Rica, Cuba, Peru, and Uruguay, decreases in death rates between 15% and 26% took place over the 10-year period. This pattern follows that of Canada and the United States. In contrast, major increases took place in some of the most rural countries like Mexico, Nicaragua, Honduras, Guatemala, Ecuador, and El Salvador.

These findings are counterintuitive, since aging and chronic degenerative diseases are positively correlated, and life expectancy is highest in more developed countries. A number of factors are probably operating together. In rural countries there is likely to have been improved reporting of causes of death over the period, as well as a true increase in deaths from cardiovascular disease commensurate with increasing life expectancy. In the more urban countries, improved treatment may have played a major role in the decreases. In addition, in the United States, one reason suggested for the decrease in deaths from cardiovascular disease is the conscious modification of the risk-producing life-style factors, including better control of hypertension, weight reduction, smoking cessation, and more exercise.

Some sources (PAHO, 1985a, 1986a) indicate that adoption of healthier life-styles is generally not happening in Latin America. Among men, for example, the risk factors of heavy smoking and alcohol consumption continue unabated. In a study of morbidity and mortality of men and women over 49 years of age over a two-year period in two hospitals in Honduras, cirrhosis and chronic alcoholism were among the most common reasons for admission among men (Carrasco and Pineda, 1987, pp. 204-205). Among women, however, not only are abuses of these drugs on the increase (PAHO, 1985a, p. 118), but a complex mixture of other factors combine to increase the risk further. In both Latin America and the Caribbean, women increasingly display the multiple and cumulative risks of obesity, high cholesterol, hypertension, and diabetes, predisposing them to cardiovascular risk. Social factors such as role conflict for working women and the pressures for economic survival described in preceding sections add to the risk in unknown ways.

A thorough discussion of one risk factor, hypertension, can be found in *Health of Women in the Americas* (PAHO, 1985a, pp. 119-125). The findings underscore the vulnerability of current and future generations of women at midlife and older to cardiovascular disease. An update on changes in cardiovascular disease as a cause of death from 1978 to 1988 for both men and women in Latin America should be high on the research priority list.

Diabetes and Hypertension

Like other chronic degenerative diseases associated with aging, diabetes is increasing throughout the Region. It is one of the five leading causes of death in 13 of the 18 Latin American countries shown in Tables 33 and 34 and 6 of the 10 Caribbean countries shown in Tables 35 and 36.

Although diabetes is a significant cause of mortality, its impact is usually felt long before death occurs. Because of its common side effects of blindness and poor peripheral circulation leading to amputation, it is also a major cause of disability.

A 1985 study of Costa Rican hospital discharges listed diabetes as the most common principal diagnosis for women 60 and over. In a family survey of over 23,000 persons conducted in Uruguay in 1982, diabetes was listed as a chronic health problem by nearly 7% of women over 60 (Ministerio de Salud Pública, Uruguay, 1984, p. 50).

The problem seems to be particularly severe in the Caribbean, where it is believed to affect between 8% to 10% of the adult population, and account for 15% to 20% of the hospital bed occupancy (Caribbean Cooperation in Health, n.d., p. 14; PAHO, 1985a, p. 143). A University of West Indies study reports that:

> of the major diseases affecting women in Barbados, diabetes is probably the most important in terms of morbidity and long-term chronicity. Over 80% of the diabetes patients in health clinics in Barbados are women [and] female diabetics outnumber males by a 3 to 1 ratio (Burke, 1983, p. 2).

Once again, several factors operating together seem to be causing the increase in diabetes. In addition to its association with aging, the disease seems to be found frequently in conjunction with two other conditions: hypertension and obesity. An informal survey of five church-based organizations with outreach health services on several of the smaller Caribbean islands listed these three problems as the major ones among their elderly female clients (C. Simon, personal communication, January 8, 1988). Burke (1983) states that in addition to diabetes, obesity and hypertension are of considerable concern among women at midlife in the Caribbean. Food and nutrition surveys conducted in Barbados in 1969, Trinidad in 1970, and Guyana in 1971 showed a prevalence rate of obesity of 28% to 39% in women, but only 7% to 13% in men. Hypertension is estimated to affect about 20% of the population of the Caribbean and is a powerful risk factor for cardiovascular and cerebrovascular problems as well as renal disease (Burke, 1983, p. 2).

The precise manner in which obesity relates to diabetes and hypertension is unknown. In developed countries, however, a reduction in weight often improves both conditions, while an increase in weight at midlife in previously healthy women may be followed by the appearance of one or both of the conditions. Obviously, other factors play a major role, too. In diabetes, heredity is thought to be a factor. In both diabetes and hypertension, psychosocial stress brought about by role conflict and rapid social change may have an influence (PAHO, 1985a, p. 143).

Because of the disabling nature of these conditions and their increasing prevalence among women at midlife and older in the Region, intensive research on the predisposing factors should receive high priority for planning adequate prevention and treatment.

Undernutrition and Anemia

Obesity can be viewed as one form of malnutrition. A more common form in Latin America and the Caribbean among women in general, but particularly among those at midlife and beyond, is chronic undernutrition. Both protein-calorie malnutrition, indicating a less than adequate diet, and anemia, in which there is a decrease in quantity or quality of circulating red blood cells, are common (DeMaeyer and Adiels-Tegman, 1985).

These two manifestations of malnutrition in older women generally begin insidiously when they are young children. According to the UN Population Division, improvements in nutrition have often lagged behind other factors involved in the reduction of mortality in less developed countries. Female children may still receive less food than their brothers, with a corresponding impact on their health (UN Population Division, 1983, p. 19).

A food survey carried out in Guyana in 1976 found that among East Indian families, the sex of the child was strongly associated with nutritional status, with boys being healthier (PAHO, 1976, p. 32). In a discussion of women's health in Mexico, Elu de Lenero reminds us that "the best preventive medicine is food" (1985, p. 67). She cites cultural patterns that result in the female child being the last priority where food is concerned, and quotes a proverb: "Cuando la comida es poca, a la niña no le toca" (When food is scarce, young girls get none).

For women a history of marginal nutrition is overlain with factors of multiple and closely spaced pregnancies, and almost continual lactation. The main common effect of this situation is depleted iron stores and resultant chronic anemia. Particularly in rural areas, where we have seen that women bear more children over longer periods of time, the two problems compound each other. The history of inadequate dietary intake coupled with increased need for iron-rich foods produces a state of chronic malnutrition that may not be reversed even when childbearing ends. A nutrition survey found that in the Caribbean the concentration of red blood cells increased in women from age 15 to age 20, remained constant until age 39, and then declined (Royston, 1982, p. 57).

Because of the need for specialized equipment and laboratory testing, it is nearly impossible to assess the actual extent of malnutrition among women of any age. The prevalence of anemia in developing countries has been estimated at 60% in pregnant women, and at 47% in nonpregnant women (DeMaeyer and Adiels-Tegman, 1985, p. 303). Both nonpregnant adolescents and older women are included in the nonpregnant category, so that rates for older women cannot be assessed.

A summary of study findings of proportion of adult women who were anemic reported by geographic region concludes that in the Latin American Region the highest percentage (37%) was found in the Caribbean, followed by 26% in Middle America, 14% in tropical South America, and 12% in temperate South America (DeMaeyer and Adiels-Tegman, 1985, p. 311).

Nutrition surveys of elderly persons have been conducted in small geographic areas with equivocal results. Weight for height measures and skinfold thicknesses and arm circumferences have been used to estimate malnutrition. These indicators are inadequate among the elderly, however, because standards are set for younger persons, and musculature for men and women differs, particularly as the body ages. In any case, these studies found that on certain measures men were at greater disadvantage, while on others women appeared to be more malnourished (Gueri, Allen, and Iton, n.d.; Mesfin, Sinha, Jutsum, Simmons, and Eldemire, 1984; Chaney, 1984; C. Simon, personal communication, January 8, 1988).

What seems to be clear is that nutritional anemia affects large numbers of adult women in the Latin American Region, and that its long-term effects can be devastating in terms of productivity and general health. Mild and moderate degrees of anemia, although tolerated by the individual, will lessen resistance to fatigue and affect work capacity under conditions of stress. Even very mild forms may influence sense of well-being and have a profound effect on physical and psychological behavior (Royston, 1982, pp. 52–53). Minimum energy stores mean minimum resources in case of emergency. As already noted, given the productive requirements of women to assure economic survival of themselves and their families, any interference with work capacity could spell disaster.

Osteoporosis

Osteoporosis refers to a process of bone loss which may result in pain, disability, and the potential for fractures. Although it can occur in men, it is most common among older women. Because bone loss rises sharply after menopause, many authorities recommend that older women increase their intake of calcium, a nutrient essential to the creation of bone tissue. Thus, it is disturbing to read the results of one study conducted among persons over 60 in Jamaica for whom blood calcium levels were assessed. Nearly 30% of the women tested had low levels of serum calcium (Mesfin, Sinha, Jutsum, Simmons, and Eldemire, 1984).

The incidence and prevalence of osteoporosis are virtually unknown in the Latin American Region. Neither is it clear whether dark skin and adequate exposure to sunlight, both protective factors, offset nutritional deficiencies and other factors which may put older women of the Region at risk. This is an area in which research is needed, but as in the case of anemia and undernutrition, the requirements of equipment and laboratory testing make this task more difficult.

Fortunately, PAHO, in collaboration with the WHO Special Program for Research on Aging at the National Institute on Aging, has begun to study this problem. Although results are several years away, they should eventually help shed light on this potentially serious health problem of older women.

Accidents and Occupational Health

With increasing numbers of women at midlife and older in urban areas and in the work force, both industrial and traffic accidents are assuming increased importance as causes of death and disability (PAHO, 1986a, p. 75). As can be seen in Tables 34 and 35, accidents are a major cause of death, even for women 65 and older.

Since 1980, the trend in industrial accidents has risen steadily. Occupational accident rates in 1980 were 10 times higher in less developed countries than in developed ones (PAHO, 1986a, p. 190). In rural areas, poisoning with insecticides and accidents involving farm machinery are the most frequent problems. These injuries are compounded by the generally low level of access to health services in rural areas (PAHO, 1985a, p. 152).

For women at midlife, work is concentrated in such industries as textiles, footwear, food production, electronics, and handicraft production (PAHO, 1985a, p. 152). Conditions in these factories may be very unsafe, with hazards such as excessive noise, light, or heat, or exposure to radiation or toxic chemicals being among the major illness-producing factors (PAHO, 1985a, p. 152).

As is generally true, no data specific to women at midlife and older are available; based on information already presented, however, it is possible to speculate. Tiano (1984), in a discussion of women and employment in the *maquiladoras* (assembly plants) along Mexico's northern border, confirms that younger women are hired preferentially and that the largest percentage of the work force is between 15 and 25 years of age (p. 9). As stated before, Chaney (1984) reported that older women may be forced out of the formal labor market in favor of younger workers. Labor force participation data confirm that rates, at least for salaried employment, fall off sharply beginning at about age 60 (see Table 19).

From these facts it might be assumed that at least older women would be less at risk for industrial accidents. In fact, except in the more highly rural countries, accidents for women over age 65 are not as prominent a cause of death as they are for women at midlife. In the more rural countries, farm work is probably responsible for maintaining accidents as a major cause of death.

For women at midlife, accidents are a leading cause of death, irrespective of country type. Despite the preference for younger workers, Table 19 documents the fact that women from 40 to 59 years of age are still employed at relatively high rates—from 16.6% for ages 50 to 59 in the rural countries to 33.5% for 40 to 49 year-olds in the more urban countries. This would argue that a combination of accidents—traffic, industrial, and farm-related—are probably responsible for the continued major role of this cause of death for women at midlife.

In a study of the health of working women, Halpert, Londoño, and Wills (1987) discuss the problem of the *doble jornada* (double shift) as an occupational risk. They cite research on married women workers in which 65% of the women interviewed worked more than 12 hours per day, and 19% more than 14 hours (p. 16). In spite of the increasing rates of outside employment, the woman's domestic world has not been reordered. Rather, the paid shift has simply been added to the unpaid one of household duties.

In a rare reference to older women, the authors contend that, in time, the pressure of this overwork causes premature aging, and it is not unusual to encounter a worker of 50 to 55 years of age who petitions for a disability pension because of a physical problem such as arthritis, intestinal disorders, etc. However, the pension system does not recognize signs and symptoms of aging as disability, and the woman must either continue to work or make other adjustments in her life to enable her to carry on. This type of situation bears directly on another kind of morbidity suffered by women at midlife and older—psychological stress and its resulting pathology.

Psychological Distress

Two approaches to understanding women's mental health exist in the current literature on Latin America and the Caribbean. One approach uses universal norms of psychological functioning that basically apply to both men and women. Deviations from these norms on the part of women are then interpreted in light of cultural, social, and environmental factors. The second approach contends that women's psychology is "something in its own right and not merely a negation of maleness" (Paltiel, 1987, p. 234).

Universal Norms

An example of the first approach is given by Duarte (1986), who states that women at midlife must give up the childbearing role. If they fail to accept menopause and to develop new interests and pursuits, the result may be depression, irritability, tension, and anxiety (p. 207). A higher incidence of depression and psychosis is seen at this stage, particularly among those whose family, social, and work lives are ungratifying. Elu de Lenero (1985, p. 66) speaks of an increase in medical consultations for neurotic symptoms which she attributes to a worsening economic crisis.

Paltiel (1987), in a discussion that encompasses aging women in developed as well as less developed world regions, states:

> The transition to old age may involve dislocation from work and home, reduction in income and in vitality, sensory loss, locomotion impairment, social-role restriction, death of partner, relatives, and peers, and, in some cases, outright or subtle abuse or neglect (p. 262).

The result of inadequate adaptation to these changes may be depression, the most common serious mental disorder in women. Elu de Lenero (1984), in the report of a conference on the health of women, echoes these concerns and adds that at midlife, feelings of powerlessness, dependency, insecurity, and lack of autonomy may become more acute, causing not only depression, but loneliness, isolation, and somatic illness.

Bianco (1985, p. 61) also discusses the greater frequency of illness and symptoms of mental illness among women. She points out that the most common symptoms in a 1980 study of urban areas were "preoccupation" (excessive worry) and "tension," both mild symptoms, but indications of the great stresses to which women are subjected in society. She attributes these findings in part to the duplication of responsibilities that comes with entering the work force and at the same time caring for a home and family—the *doble jornada* discussed above.

Some authors using this approach also contrast the mental health of men and women. Duarte (1988) describes a tendency for women to report a larger number of symptoms such as sadness, irritability, fatigue, forgetfulness, headaches, fainting, and trouble sleeping. A cultural stigma against mental illness for men prevents them from expressing these symptoms. Instead, they channel their feelings into more acceptable forms of obsessive or hypochondriacal behavior; physical illness is less threatening than mental illness (p. 207).

Paltiel (1987) reports the results of community surveys which generally found women to be more symptomatic and psychologically disabled. There were also diagnoses that showed gender specificity. Depression was more common among women, while personality disorders with concomitant irresponsible and antisocial behavior were found more often in men (p. 238). Paltiel also provides a transition to the second approach to discussions of psychological distress. She quotes a report on women's mental health in Latin America and the Caribbean which observes that: "women's status in all countries has elements of inequality and disadvantage that affect emotional health and hinder rehabilitation of those who develop problems" (p. 233). She points out that prior to the UN International Women's Decade, investigation of mental health had been oriented toward deviations from standards based on masculine norms and values. It is not surprising "that the mainstream literature pays little attention to the mental health effects of discrimination, [which is] not a discrete life event, but a pervasive condition of women's lives in both developed and developing countries" (Paltiel, 1987, p. 233).

Gender-specific Norms

Those who use the second approach to discuss women's mental health in the Region have identified the origins of discrimination in the concept of *machismo*. This is a term used to describe a complex system of male dominance which has prevailed in Latin America and, in a slightly different form, in the Caribbean, since the Spanish conquest. Although originally designed in the Middle Ages to preserve power in the hands of an elite by controlling women's sexual behavior and thus patterns of inheritance, it has evolved into a pervasive cultural pattern not limited to the upper classes and incorporating itself into all aspects of men's and women's lives (Freire, 1983, p. 2).

Under this system, clear dichotomies exist between male and female behavior. Men are required to be strong and women weak and dependent. Men must be aggressive and women submissive. Men should be preoccupied with sexual conquests, while women should maintain a strict fidelity and a nearly asexual demeanor. Men should rule in the social and political arenas, while women (with male supervision) are allowed to run the home. Men should maintain distance from young children and their care, and can be expected to mistreat family members. A man's role in the family is as an economic provider and decision maker. The woman is expected to do everything else (Munoz de Vera, 1982).

The socialization to these male and female roles is powerful, particularly in rural areas. The major agent of socialization is the mother, under whose tutelage the young girl learns to be *el sexo débil*, the weak sex. She is shielded from outsiders while her brothers are allowed to roam, being *de la calle*, of the street. Play is strongly related to sex roles and is a major influence, especially in isolated rural areas. For girls it revolves around dolls, cooking utensils, and buying, preparing, and selling food. When contact between the sexes is allowed at special occasions, each sex seeks its own, and participation is once again clearly delineated along gender lines (Muñoz de Vera, 1982).

When girls grow into women, the effect of a lifetime of socialization under this system, according to Bourque and Warren (1981), is sexual subordination. The sexual subordinate is "one that is deemed to be inferior, devalued, second-class, dependent, dominated, exploited" (quoted in Lavrin, 1984, p. 47). Aresti and Emmer (n.d.) point out that the concept of mental health for women of the Region historically has included passivity and availability for "use" by others, both sexually and intellectually. The authors ask how mothers could transmit to their daughters this message of "impoverishment, mutilation, minimization of their vital interests and reduction of their existence." Their answer is that this role is accepted almost unquestioningly by both mother and daughter as "natural" and this is reinforced at every turn by society (p. 54).

Even when there is a conscious desire to change these patterns, the weight of centuries is difficult to dislodge. In Cuba, therefore, a family code was issued in 1975 declaring female equality. This was combined with day care, maternity benefits, and other protections to encourage women to join the labor force (Lavrin, 1984, p. 185). Although there may be some effect on younger women, for older women, these changes came too late.

In an interview with the 54-year-old mother of a young woman patient who wanted a divorce from a severely abusive and neglectful husband, psychologist Nelly Sanchez reports that the woman could not understand her daughter's desire to be free of such a "good" husband. She herself had been a single mother raising her children alone. She was terrified to think of her daughter being left without the meager economic support offered by her spouse. Her daughter's plight, though she was suicidal and her children in foster homes, was seen by her mother as "natural" for a woman and preferable to a life of working "on the street" as a laundress as she had done (Sanchez, 1983).

Clearly this approach to the study of mental health among women in Latin America is an important beginning, but many years of research will be needed before it yields appropriate and successful interventions. We hope it will not require the centuries that have been spent producing the problem. In a discussion regarding the Caribbean, Peattie (1979) makes a point which those doing comparative research would do well to remember: although women claim men are supposed to be the "head" of the household, they socialize boys to be lazy and irresponsible and *they* do the providing. Peattie asks, "Is this poor planning or is it something else? Women who know that there have been times and social classes in which they have been systematically socialized for charming incompetence should recognize that when they see it coming round the other way" (p. 128).

Sexuality and the Post-menopausal Woman

There is a small but growing handful of Latin American researchers who are addressing the issue of sexuality and female aging. Ambivalence about sexuality is a longstanding legacy of cultural norms in Latin America and the Caribbean. Studies of women's perceptions of their bodies have been conducted among women in the popular sector of Santiago, Chile, by Rodo (1987), and Sanchez's (1983) study of the psychology of women in Cuba treats the issue in a number of forms, including frigidity and prostitution. *Especial-Mujer,* a series with periodic publications centered around various themes, has made available collections of articles from the popular press dealing with women and *machismo,* women and sexuality, and women and maternity, among others.

Although their work is important to Latin American women, Cardinal de Martin (n.d.) feels that many of these researchers, by focusing their work among young women, are perpetuating the belief that a woman's sexual life ends with the capacity to reproduce. Her work centers around teaching women how to achieve sexual health after menopause. The issue of *Especial-Mujer* dealing with "Mujer y Tercera Edad" (woman and aging) reproduces several articles dealing with sexuality, menopause, and aging. Thus, the topic has not been completely neglected in the popular press.

Menopause has also been studied by Barnett (1986) among women in a Peruvian town. Her most important finding was that acceptance and adjustment to menopause was dependent on satisfaction with the woman's principal life role. Two major roles were available, that of mother and of laborer. Mothers whose children did not meet their expectations had more difficulty during menopause, while laborers, whose satisfaction depended not only on their children, but also on their own behavior, fared better. This finding may have implications when a larger cohort of women who have been economically active all their lives reaches menopause. Will these women adjust better to menopause than women have in the past because their satisfaction depends more directly on themselves? This may be a fruitful area for future research.

The causes of illness and death among women at midlife and older differ from those of younger women. In the next section, the response to these differences by the Latin American and Caribbean health care systems will be explored.

THE HEALTH CARE SYSTEM AND WOMEN AT MIDLIFE AND OLDER

The recognition of the unique health care needs of an elderly population is something that grows slowly in developing countries, increasing as the proportions of older persons in the population increase. Since women are the largest users of the health care system, this may be one area in which they have a certain advantage. Services are provided, when possible, on the basis of identified needs, and, as the female population ages, the needs of older women become more evident (ISSA, 1982).

At the same time, women's roles as health care givers, both professionally and as lay community health workers, are being increasingly scrutinized. Before examining the involvement of women at midlife and older, an overview of the nature of Latin American and Caribbean health care systems is in order.

Primary Health Care

All countries in the Region have affirmed the WHO goal of health for all by the year 2000. All have subscribed to the principle of equal access to health services, and most have assigned priority to vulnerable groups. Among these groups are women and the elderly, but not necessarily elderly women. Plans for achieving these goals usually center around the concept of primary health care. The strategies of this approach include health education, maternal and child care, immunization, nutrition, and control of environmental hazards such as infectious diseases and accidents (PAHO, 1986a, p. 134). The system of health care delivery is usually tiered and pyramidal, with many health posts as the foundation. At least two other levels are usually present: an intermediate level with fewer facilities serving a larger area but offering more complex care, and often at the apex, a large teaching hospital and medical school located in the capital city.

Although this is the basis of health policy in the nations throughout the Region, the individual countries vary greatly in how and to what extent they have successfully implemented these plans. Part of the success of a health program depends on the government's investment in it. According to Mesa-Lago (1986) about half the cost of social security in the Region is accounted for by health programs, and the percentage of gross domestic product spent on health care of some countries rivals that of the United Kingdom, which with a 5% expenditure has one of the most advanced systems in the world. Costa Rica, for instance, spends 6%; Panama 5%; and Brazil, Chile, and Colombia, 4% (p. 149).

Table 38 and Figure 6 look at the countries' expenditures slightly differently, giving the median amount (in 1982 US dollars) per person spent on health for three time periods—1970, 1980, and the latest year for which data were available in each country between 1981 and 1984. The data for 1981-1984 represent the effects of the recent economic crisis on health care expenditures. Figure 6 shows that, although countries of all types could increase expenditures on health from 1970 to 1980, some ground has been lost since then in all cases, except in the Caribbean. Rates of increase were highest from 1970-1980 in the rural and mixed countries, but it must be kept in mind that expenditures were already high in the more urban countries.

The rural and mixed country types used throughout this report correspond, with few exceptions, to the low and medium divisions of countries described by Mesa-Lago and presented in Table 29. Since in these countries the largest expenditure of social security income by governments is on health (up to 80%), it is possible to assume that much of the increase in the rural and mixed countries came in the form of increased health services.

Clearly, the rural countries still lag far behind the others in terms of the per capita expenditure on health care. It is also true that expenditures in

Table 38. Median central government expenditures on health per person by country type and for the Caribbean; 1970, 1980, and 1981-84.

	Year		
Country type	1970	1980	1981-84
Highly urban[a]	21.16	26.38	21.44
Mixed[b]	10.66	23.89	20.29
Highly rural	3.83	11.81	10.10
Caribbean[c]	—	64.63	70.41

Source: Adapted from Pan American Health Organization, 1986a, p. 184.

[a] No data for: Argentina, 1970; Cuba, all.

[b] No data for: Mexico, 1970, 1981-84; Peru, Panama, and El Salvador, 1970.

[c] No data for Trinidad and Tobago, Bahamas, and Suriname, 1970.

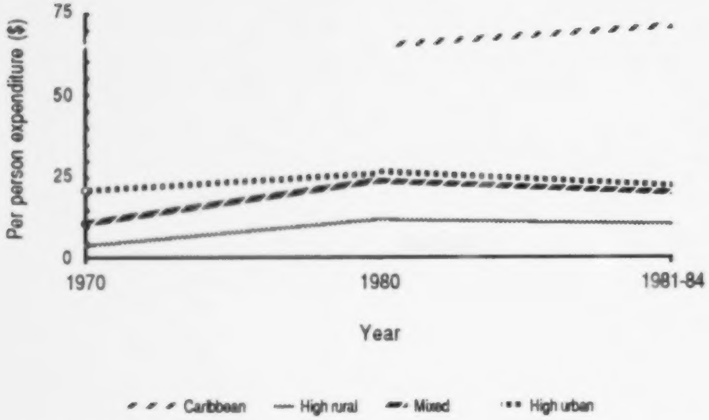

Figure 6. Median central government per person expenditures for health by country type in 1982 adjusted US dollars for 1970, 1980, 1981–1984.

the Caribbean are extraordinarily high in comparison with any in Latin America. The use of average values obscures many variations, none more so than in the Caribbean. Two countries, Barbados and the Bahamas, spent $224.83 and $118.98, respectively, per capita in 1984 for health care (PAHO, 1986a, p. 184).

Organization of Services

Mesa-Lago points out that higher percentages of a country's wealth devoted to health does not necessarily produce improved overall health conditions. This is largely due to the fact that funds may be distributed inappropriately for the benefit of the few at the expense of the many. Even in Costa Rica, a country which is rightfully hailed as a model and in which virtually all persons have statutory health coverage, many inequities exist. The Ministry, which is responsible for primary health care of low-income groups in rural and urban marginal areas, control of communicable diseases, monitoring of immunization, drugs, environmental hazards, and child nutrition accounted for only 12% of the nation's health expenditures in 1979, while the organizations responsible for curative care spent 75%. In fairness, these discrepancies have not gone unnoticed and efforts are being made to remedy them, but powerful interest groups—particularly labor unions and physicians—stand in the way of a more balanced and efficient use of funds (Mesa-Lago, 1985, p. 20).

Another factor influencing the hospital-focused use of health care dollars is the feeling, common among health care planners, that primary health care is a rural strategy that has no place in urban settings. Yet many urban poor and elderly do not have access to these curative services even though they live in urban areas (Wren, 1988, p. 9). As Elu de Lenero (1985) points out, it is an error to think of accessibility of services in terms of geographic distance alone. Cultural, physical, financial, communication, and other barriers continue to exist although a hospital may be located only a short bus ride away (p. 67).

The Community Focus of Primary Care

Recent efforts by those who want to expand coverage have concentrated on two areas: decentralization of services and decision making, and community involvement in planning and delivering of primary health care. Decentralization is viewed as a method of reducing costs, inefficiency, and problems of communication by investing local officials in the successful outcomes of their programs (P. Harrison, personal communication, 1986).

Although community participation has been part of the primary health care policy in most countries from the beginning, implementation has too often involved imposing western health care models, rather than allowing traditional organizational forms to dictate which type of involvement is desired and feasible. Stebbins (1986), in a study of a Mexican rural health initiative in an isolated Indian village, summarizes the reasons for the program's lack of success:

> . . .the clinic reflects the national culture, the national world view, and biological understandings of health and disease, and shows virtually no knowledge of, interest in, or sensitivity to the Chinantec culture and world view (p. 145).

Ugalde (1985) feels that two erroneous assumptions are responsible for the failure of community participation: the belief that traditional values are the major obstacle to health improvements and the idea that traditional people cannot organize themselves (p. 47). These assumptions are not only false, but have served to perpetuate the low-quality health services found in rural areas by blaming the victims (Ugalde, 1985).

Care of the Elderly

The call for community participation has been particularly strong where care of the elderly is concerned. A background document prepared for the 1982 World Assembly on Aging by the International Social Security Association warned planners in developing countries against adopting western models of institutional care without due consideration. . .

> Here we enter a field where the lesson to be drawn from the experience of the economically more advanced countries could, for the developing countries, indicate not that they should follow it but on the contrary that they should try to maintain the unity and cohesion of the family and other natural groups threatened by modernization and urban development (p. 43).

In Costa Rica, a policy paper on aging states that the basic premise is that the family has principal responsibility for care of the elderly. The state's role is to substitute for this group only in cases of abandonment or absence of any family (Brenes, 1987b, p. 3). Maintenance laws in Jamaica require individuals to support their parents and grandparents if necessary (Eldemire, 1988, p. 6). In Barbados, Brathwaite (1988) states that "at the institutional level, the predominant emphasis on institutionalized care is gradually giving way to an emphasis on family and community-based care" (p. 25). In Mexico, Contreras de Lehr (1987) reports that nursing homes have a negative image and are viewed as a "substitute solution" for family care.

In fact, the success of programs for the elderly involving community participation has been spotty, with better results being reported in the Caribbean, perhaps partly as a result of the greater financial commitment of the governments there (Simon, personal communication, 1988; Eldemire, 1988; Stark, 1985; Elu de Lenero, 1985; Stebbins, 1986). Eldemire (1988) reports several successful programs in Jamaica designed to provide support for the family in their efforts to care for elderly members. She describes day care centers, outpatient clinics, domiciliary/home care, ambulatory services and mobile health units. She reports that the Jamaican government has put much emphasis on home care as a support to families because institutional care is too costly for developing countries.

Institutional Care

In Panama an elaborate set of programs for the elderly is partially in place. Lopez (1988) relates the experience of conducting a needs assessment in preparation for these programs. The services most in demand were admissions to nursing homes, economic support, family counseling, and hot meals. He observed that many of the elderly for whom nursing home placement was requested were only around 55 years old. Reasons for the requests were unwillingness to provide economic support, fear for the person's safety and comfort while other family members were working, and family conflict.

Rejection of the aged is a problem often mentioned but rarely discussed. Lopez (1988) states that many of the requesting families had low incomes and poor education, and lived in very crowded conditions in poor neighborhoods. The set of programs ultimately developed were designed to assist families to care for their elderly members and to ease the burden of this care. However, Lopez points out that this goal cannot always be maintained.

> Every day one sees elderly beggars and homeless seniors. Sometimes they are people living in condemned housing, under staircases, and in other inadequate places. Sometimes these homeless people have family or relatives, but the family doesn't want to take any responsibility for them due to their past behavior. Since most of the time the elderly involved are very poor, they have no other choice than to live in the streets, parks, and other inadequate places (p. 26).

The solution in Panama City was to build shelters for the homeless. Although Lopez does not give any demographic information, it is well known that elderly women are the poorest of the poor. Whether or not they also make up the majority of the homeless is another question, since cultural values particularly stress care of the older women, and disruptive behavior that would cause rejection is more likely to occur in males socialized to aggression.

Although Jamaica's health plan stresses community and home-based care, Eldemire (1988) concedes that in some cases this is not possible and nursing homes and homes for the aged are part of the plan also. She says, however, that there is a common myth, unsupported by statistics, that many elderly are incapacitated and in homes. To counter this, she relates that in 1983 there were 13 infirmaries throughout the island with a total of 1,904 residents, most of them over 60 years of age (p. 6). This represents only .8% of the 1984 over-60 population of Jamaica. Again, without disaggregated data it is not possible to tell how many of these residents were women, but given women's higher life expectancy in general, it is fairly safe to say that the majority probably are women.

Contreras de Lehr (1987) also describes situations in which it is not possible to maintain the elderly in the community. Although data from Mexico are incomplete, she believes that the country presently has approximately 150 homes for the aged supported by church, private, or public funds. The available capacities and current occupancy rates are not known. Conditions in many of these homes are known to be very poor, with some of them offering nothing but food, shelter, and occasional medical care. The National System for Integrated Family Development (DIF) is beginning a program of physical rehabilitation of the homes and training of staff that is designed to greatly improve the quality of life of those living there.

Women as Care Givers

Some authors who have been evaluating the lack of success of community-based initiatives have expressed concern that part of the problem is that women are already the major care givers. By introducing a formal role such as "health promoter" without relieving women of other duties or making the position financially lucrative so they can reduce their other economic activities, the new role is simply an added burden (Leslie, Lycette, and Buvinic, 1986; Gay, 1987). An interesting point, unmentioned by all who have critiqued the community participation aspect of primary health care in Latin America and the Caribbean, is that *whatever* care is given—in hospitals, nursing homes, or in the community—most of it will be given by women.

Women are overrepresented in the health and helping professions (Chaney, 1984). A study of women health workers in Argentina calls the entire health sector a "women's sector" with women constituting 60% of employees. This study by Wainerman and Geldstein (1985) is the only one we found that explored the characteristics of women health workers. One finding was that women health workers tended to be older, although exact ages were not given. The authors speculated that both the years of education required and, in the case of nursing, the hard work involved, made the field unattractive to young people and helped account for this finding (p. 42).

Coverage is very difficult to assess. Although national data are available, as Scott (1988) points out, ratios of health workers to population are meaningless because of differences in distribution and access to health services within countries (p. 30). Although it was not possible to locate specific data on the rural-urban distribution of health workers, the author's experience and discussion with faculty at the Department of Nursing Education at the Autonomous University of Honduras indicate that the burden of care by auxiliary nurses is increasing in rural and marginal urban areas.

A large percentage of auxiliary nurses are women at midlife and older (WHO, 1985). These nurses are the workhorses of the health care system. Their training varies from one country to the next, but generally consists of a three-to-six grade primary education and six months to one year of technical training. In some cases, the literacy level is so low that auxiliaries are unable to complete reports and read instructions. Yet they are entrusted with both the administration and care delivery in most basic health posts. Supervision of auxiliaries varies greatly, as does the level of financial, technical, and material support supplied by the health care system.

Although they still constitute the majority of nursing personnel in Latin America (64% auxiliaries versus 36% nurses), their numbers in relation to the population have decreased. During the period from 1972 to 1984, while the number of nurses per 10,000 population increased by 93%, the numbers of auxiliaries decreased by 21% (PAHO, 1986a, p. 137). Unfortunately, this does not necessarily mean that better-educated health personnel are available to the population. Again, population coverage depends on distribution, and auxiliary nurses continue to be overrepresented in isolated rural areas.

The difficulty with starting new programs and new categories of health personnel such as the community health promoter is not just that an extra burden of work is added to the health promoter, who is usually a woman. The responsibility for monitoring, administering, and supervising any new program in an isolated health post falls to the only person available, the auxiliary nurse—also almost invariably a woman. An example from rural Nicaragua makes the point. Ninety *brigadistas* (community health workers) served approximately 10,000 persons. Twice a week the auxiliary nurse visited the main villages assisted by the *brigadistas*. The author of the report states:

> When visited, the nurse auxiliaries were found to be doing most of the hands-on-work and health education, with the *brigadistas* offering assistance when asked (Schall, 1985, p. 212).

In the case of a woman auxiliary and a male health promoter, cultural roles may well make formal supervision impossible.

Thus, although there are fewer auxiliaries, their workload has increased, as has the workload of the lay health promoter. Is it really any wonder that community participation in primary health care has not been successful? Until program planners in the countries and in the international funding agencies begin to look at the situation from the perspective of an almost entirely female population of lay and professional health care providers, their understanding will continue to be incomplete.

However, there is more at issue in the failure of community participation efforts than their disregard of the overwhelmingly female composition of the primary care labor force. Ugalde (1985) points out that "the degree of success of any form of community participation is inversely correlated to the degree of social stratification of the society" (p. 49). True community participation by its very nature creates demands on health care systems. It is a political activity that often leads to violence when social awareness is awakened. Until governments in the Region are in a position to support their rhetoric with continuing material and financial assistance, little will change with regard to health care for a majority of their citizens.

OBSERVATIONS AND RECOMMENDATIONS FOR RESEARCH

The final section of this report is yet to be written. It is still too early in the study of women at midlife and older in Latin America and the Caribbean to draw firm conclusions. The current section emphasizes major points and makes observations based on information either presented or that was conspicuous by its absence. Broad research recommendations conclude the report.

Observations

In cultures where the attributes of *machismo*—male strength, aggressiveness, sexual appetite, and irresponsibility—are valued as highly as they are in most of Latin America and the Caribbean, it is inevitable that women adopt subordinate and subservient roles. For most women in the Region, male domination is a fact of life, and this has been widely documented. Paredes-Vasconez (1982) states the matter bluntly: "in Latin America the condition of women is in good measure determined by the macho attitude of men" (p. 11).

Equally well known is the manner in which culture and politics conspire to maintain this gender imbalance. The agents of socialization are powerful, particularly in rural areas (Muñoz de Vera, 1982). The unequal worth of men and women is confirmed at birth, when sometimes midwives charge less if the child is a girl (p. 132). The accepted roles are strength for men and weakness for women, and mothers reproduce in their sons and daughters the attitudes and behaviors they were taught by their own parents and which were reinforced by school, church, and the community.

In some countries, laws favoring men further contribute to subordinate women (Campana, 1982, p. 157). In others, while a *de jure* equality is guaranteed, the *de facto* application of the laws continues to keep women at a disadvantage. In seven countries in the Region, women received the right to vote only in the 1950s, and in Paraguay, not until 1961 (PAHO, 1985a, p. 41). Though able to vote, they lack the education, experience, background, and cultural support to exercise this right, much less to become politically active.

We have seen that although access to education is improving for girls, the schooling they receive still does not prepare them to assume positions of authority and responsibility in the community; rather, it reinforces their culturally prescribed roles. Even when women manage to move ahead in the educational system, it is usually in careers such as teaching, social work, and health-related professions such as nursing, which are extensions of their traditional responsibilities. And even when women are better trained than men in a given specialty, they are paid much less to practice it.

The enormous burden of work borne by women has been amply documented. Their comments on the subject, however, are rarely heard. Spindel (1982) asked rural women if they preferred to work at home or alone in the fields. The role to which they had been socialized—caring for the home—was overwhelmingly *not* their choice, even among older women. The reasons they gave for their preference were that work in the fields had a beginning and an end, but housework was never finished; work in the fields was tranquil, while in the home, one's head ached; and field work occupied only the body, while housework required everything, the mind and all the rest (p. 242).

Women's work, whether at home, in the fields, or in a profession, is undervalued and discounted. Often it is literally not counted, so that in the statistical reports emanating from countries in the Region, it appears that most women do not "work" at all. Women's employment is usually low-level work and poorly paid. It is also by necessity, because of home and child-rearing responsibilities, frequently part-time and seasonal, making them ineligible for pension assistance when they are elderly. This reinforces their dependence, either on their children or on the usually meager economic assistance programs available in their country, and sometimes both.

The health of women at midlife and older is, in large measure, a function of their culture and experiences. Although both genetic predisposition and volitional risk-factors such as smoking and alcohol consumption play a part, they are overshadowed by the weight of the physical and emotional burdens placed on women by their subordinate status. Their treatment for chronic illnesses such as depression, anxiety, diabetes, hypertension, arthritis, and cardiac problems exceeds that of men, as does their use of medical care services. Yet, in most cases, their life expectancy exceeds that of men by several years.

Even after menopause, when their cultural usefulness (childbearing) is finished, they continue to be the mainstays of many families. In some of these large, extended families, found among the poorer classes and in rural areas, they not only bring in income from a variety of informal sources, but they also have the major responsibility as care givers to their grandchildren and sometimes to their own elderly parents. In short, they remain the epicenter of the family, providing continuity and stability in the face of overwhelming social change.

Research Recommendations

One goal of the study has been to stimulate more research on the subject of women at midlife and older in the Latin American Region. There has been no systematic effort to identify specific areas in which more research is needed. In terms of research, the entire topic is both ripe with possibilities and urgently in need. In cases where the need was especially obvious, or especially critical, this has been pointed out in the text. These tend to be areas such as education, where data are incomplete, or health, where more must be known about current status before rational and effective interventions can be developed.

Aside from the demographic and health information presented in this report, studies specific to women at midlife and older are almost nonexistent. There are no descriptions of their daily lives, and few efforts have been made to examine their attitudes and practices related to specific factors. These include such areas as support networks among widows (Sanchez-Ayendez, 1984), menopause (Barnett, 1986), and sexuality (Rodo, 1987). This is an encouraging trend, as it involves universal aspects of women's lives and thus lends itself well to cross-national research. One other type of research, the large country survey, such as is being conducted by PAHO in 13 countries, shows promise in that it taps a large, representative random sample and probes attitudes toward health and aging. Information from these studies should help close the gap in our understanding of the opinions and perceptions of older persons.

What comes out clearly in the research literature to date on subjects of concern to midlife and older women is a pattern of official neglect of their interests and needs. This is true as much of the research and statistical data which, until recently, was not disaggregated by sex, as it is of services which often are still not disaggregated by age. If women are undervalued, then older women must be the most undervalued of all. Perhaps the most critical need is for research which takes a life-stage approach to understanding women's experiences in Latin America and the Caribbean, and shifts the spotlight and the microscope from the earlier to the later part of women's lives.

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APPENDIX

Percent of women economically active by cohort, by country, 1950–1980.

Age in 1950	1950	1960	1970	1980	Age in 1980
Argentina					
10–14	8	26	24	31	40–44
15–19	26	22	24	25	45–49
20–24	24	21	23	25	50–54
25–29	20	20	22	21	55–59
30–34	19	20	20	15	60–64
35–39	18	19	17	8	65–69
40–44	18	18	14	—	—
Uruguay					
10–14	6	40	37	42	40–44
15–19	31	38	36	38	45–49
20–24	39	33	34	33	50–54
25–29	37	32	31	24	55–59
30–34	32	28	26	13	60–64
35–39	30	26	18	4	65–69
40–44	26	22	12	—	—
Chile					
10–14	5	32	26	30	40–44
15–19	28	28	24	28	45–49
20–24	33	24	23	22	50–54
25–29	23	22	22	16	55–59
30–34	19	22	20	12	60–64
35–39	18	21	16	6	65–69
40–44	19	19	12	—	—
Venezuela					
10–14	5	26	26	37	40–44
15–19	23	24	24	30	45–49
20–24	24	23	23	25	50–54
25–29	22	22	20	18	55–59
30–34	20	21	18	15	60–64
35–39	20	19	13	6	65–69
40–44	19	17	10	—	—
Cuba					
10–14	5	26	26	37	40–44
15–19	23	24	24	30	45–49
20–24	24	23	23	25	50–54
25–29	22	22	20	18	55–59
30–34	20	21	18	15	60–64
35–39	20	19	13	6	65–69
40–44	19	17	10	—	—

APPENDIX, Continued

Age in 1950	1950	1960	1970	1980	Age in 1980
Brazil					
10–14	9	23	25	31	40–44
15–19	24	19	24	29	45–49
20–24	20	18	23	25	50–54
25–29	15	16	21	21	55–59
30–34	14	17	18	14	60–64
35–39	13	16	15	6	65–69
40–44	13	15	12	—	—
Mexico					
10–14	4	20	16	30	40–44
15–19	15	16	16	29	45–49
20–24	16	14	15	28	50–54
25–29	15	14	16	26	55–59
30–34	12	14	16	24	60–64
35–39	12	15	15	18	65–69
40–44	12	14	14	—	—
Colombia					
10–14	10	26	23	22	40–44
15–19	24	21	21	22	45–49
20–24	24	20	21	16	50–54
25–29	20	20	20	14	55–59
30–34	19	20	17	10	60–64
35–39	19	19	16	6	65–69
40–44	19	18	12	—	—
Peru					
10–14	10	26	22	27	40–44
15–19	29	24	20	26	45–49
20–24	26	21	21	25	50–54
25–29	24	20	20	23	55–59
30–34	20	20	18	22	60–64
35–39	19	20	17	12	65–69
40–44	20	20	14	—	—
Nicaragua					
10–14	7	22	23	24	40–44
15–19	15	21	23	20	45–49
20–24	17	21	23	19	50–54
25–29	15	21	21	18	55–59
30–34	14	21	20	14	60–64
35–39	14	21	18	9	65–69
40–44	14	20	15	—	—

APPENDIX, Continued

Age in 1950	1950	1960	1970	1980	Age in 1980
Dominican Republic					
10–14	3	12	13	14	40–44
15–19	10	12	13	14	45–49
20–24	12	12	13	11	50–54
25–29	12	12	13	11	55–59
30–34	12	13	10	9	60–64
35–39	12	13	11	4	65–69
40–44	12	10	9	—	—
Panama					
10–14	6	31	33	36	40–44
15–19	23	28	32	31	45–49
20–24	30	28	31	23	50–54
25–29	25	28	29	16	55–59
30–34	25	26	25	11	60–64
35–39	25	26	21	5	65–69
40–44	24	22	15	—	—
Costa Rica					
10–14	4	24	22	22	40–44
15–19	22	20	21	20	45–49
20–24	24	18	19	16	50–54
25–29	18	18	16	12	55–59
30–34	16	16	13	8	60–64
35–39	16	15	11	3	65–69
40–44	15	13	8	—	—
El Salvador					
10–14	4	24	22	22	40–44
15–19	22	20	21	20	45–49
20–24	24	18	19	16	50–54
25–29	18	18	16	12	55–59
30–34	16	16	13	8	60–64
35–39	16	15	11	3	65–69
40–44	15	13	8	—	—
Ecuador					
10–14	10	22	18	21	40–44
15–19	24	17	17	20	45–49
20–24	20	16	17	17	50–54
25–29	15	16	16	16	55–59
30–34	15	17	16	14	60–64
35–39	16	16	15	10	65–69
40–44	17	17	13	—	—

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APPENDIX, Continued

Age in 1950	1950	1960	1970	1980	Age in 1980
Paraguay					
10–14	7	30	26	24	40–44
15–19	26	28	24	21	45–49
20–24	28	26	23	18	50–54
25–29	25	24	21	16	55–59
30–34	24	23	19	13	60–64
35–39	24	25	17	7	65–69
40–44	23	22	14	—	—
Bolivia					
10–14	17	24	23	23	40–44
15–19	23	23	22	23	45–49
20–24	22	23	22	21	50–54
25–29	22	22	22	19	55–59
30–34	22	22	20	17	60–64
35–39	22	22	19	14	65–69
40–44	21	20	17	—	—
Guatemala					
10–14	6	15	14	14	40–44
15–19	17	13	13	12	45–49
20–24	16	13	14	12	50–54
25–29	13	13	13	10	55–59
30–34	13	13	13	9	60–64
35–39	13	14	12	7	65–69
40–44	13	12	10	—	—
Honduras					
10–14	5	18	16	18	40–44
15–19	15	14	16	16	45–49
20–24	16	13	15	14	50–54
25–29	13	12	14	13	55–59
30–34	12	12	13	11	60–64
35–39	12	12	12	7	65–69
40–44	11	11	10	—	—
Haiti					
10–14	52	81	74	67	40–44
15–19	81	80	75	68	45–49
20–24	86	80	78	67	50–54
25–29	85	81	77	65	55–59
30–34	86	82	77	58	60–64
35–39	86	82	76	40	65–69
40–44	87	81	70	—	—

APPENDIX, Continued

Age in 1950	1950	1960	1970	1980	Age in 1980
Barbados					
10–14	10	60	52	80	40–44
15–19	54	54	53	80	45–49
20–24	63	54	52	79	50–54
25–29	58	54	55	55	55–59
30–34	58	54	53	45	60–64
35–39	58	57	51	8	65–69
40–44	58	55	41	—	—
Puerto Rico					
10–14	1	32	36	34	40–44
15–19	21	30	35	28	45–49
20–24	29	29	31	23	50–54
25–29	27	27	25	16	55–59
30–34	26	25	21	11	60–64
35–39	25	22	15	3	65–69
40–44	23	18	11	—	—

Part II

PROCEEDINGS OF THE CONSULTING GROUP MEETING ON MIDLIFE AND OLDER WOMEN IN LATIN AMERICA AND THE CARIBBEAN: CURRENT SITUATION AND POLICY IMPLICATIONS

INTRODUCTION

Part II of this document contains the papers presented at the PAHO/AARP Consulting Group Meeting, "Midlife and Older Women in Latin America and the Caribbean: Current Situation and Policy Implications," held 18–20 October 1988 in Washington, D.C. The papers focus on specific issues relating to this population segment and present either the results of original research, a reanalysis of previously collected data, or suggestions for policy directions to meet emerging needs. The papers are divided into four sections: health, psychosocial aspects, economic issues, and regional and national perspectives.

Setting the stage for discussion of these topics are statements by two women in unique positions of influence. Opening remarks were made by Louise Crooks, President of the American Association of Retired Persons, and the keynote address was given by Ambassador Julia Tavares de Alvarez, Alternate Representative to the United Nations from the Dominican Republic. Ms. Crooks expresses her hope for an enduring dialogue on this subject. Ambassador Alvarez suggests that such dialogue should include young women, who will ultimately benefit from gains made by the present generation of older women.

Although health in the fullest sense encompasses many aspects of life, the papers reprinted in the first section concentrate on overt manifestations of ill health in midlife and older women and the services available to them. One theme that runs through the presentations, both in this section and in those that follow, is the lack of attention by national and local governments to the unique needs and problems of women in this age group. As regards health, this translates into health services more geared to the acute problems of younger women, such as complications of pregnancy, and a lack of services to deal with the effects of chronic disease and a lifetime of malnutrition. Other subjects touched on are occupational health, the impact of lifestyle factors on morbidity, and rural/urban and socioeconomic group differences in health status.

In the next section, participants address some of the social and psychological issues that influence the situation of midlife and older women in Latin America and the Caribbean. The section begins with a report that traces the development of international approaches to social policies and planning for this population segment. The five subsequent papers explore aspects of older women's experiences in four different countries in the Region, broaching subjects as varied as widowhood, sexuality, social support systems, and self-perception of aging. Although they reflect small, isolated studies, the results presented here establish the importance of learning older women's attitudes and opinions and offer suggestions for incorporating these findings into social policy planning.

If one had to choose a single factor that has had the strongest impact on the situation of midlife and older women in Latin America and the Caribbean, it would undoubtedly be lack of economic security. The papers in the third section discuss various adaptations older women have had to make in response to overwhelming societal changes, including the disintegration of the peasant agricultural economy, migration to urban areas, and the recent debt crisis. The papers point out the increase in labor force participation by women in general, including older women, and they address related subjects such as women's changing familial roles, eligibility for social security benefits, and the need for legislative protection to guarantee the rights of working women.

The final section of these proceedings includes papers that focus on demographic and policy issues in specific geographic areas. A report on the Caribbean area broadly discusses economic issues, family and household structure, education, and health. A paper on elderly women in Mexico points out that the aging of the population is a very recent phenomenon in that country, as it is in many developing countries, and thus further study will be required for a deeper understanding of its ramifications. The other papers focus on how various issues relevant to older women are being approached at the national level in three other countries: Venezuela, Puerto Rico, and Costa Rica.

Despite this intensive examination of the situation of midlife and older women in Latin America and the Caribbean, it is notable how much more needs to be discovered and understood before a Region-wide plan to address the issues facing this group can be proposed. However, the papers included here give ample direction in this regard.

A common thread in this volume is the enormous ingenuity of older women, who, although trained from birth to be dependent, have taken on tremendous responsibilities and surmounted incredible obstacles. It is indeed ironic that the same repressive system of socialization that maintains women as subordinate, second-class citizens also trains them to use physical, emotional, and intellectual resources and survival skills that were virtually unrecognized until recent descriptions of female economic and social activities became available.

The voices that are missing here are those of the older women themselves. Perhaps a next step is to make it possible for midlife and older women to articulate the nature of their hard-gained knowledge and skills, so that these resources can be used consciously for their own benefit.

OPENING STATEMENT

Louise Crooks[1]

It is indeed a great pleasure to be asked to give some opening remarks on the occasion of the joint AARP/PAHO Consulting Group Meeting on Midlife and Older Women in Latin America and the Caribbean. This is in many ways an historic occasion, since it is the first time that our two organizations have joined together to focus attention on an important issue—the aging of the population—facing all the countries of the Region of the Americas. Today is also historic because, to the best of our knowledge, it marks the first time that an international meeting has been held specifically to discuss the situation of older women in the Region. Other meetings have concentrated either on the elderly or on women in general, but never before has the expertise of the Region been brought together to examine the specific concerns of midlife and older women.

An occasion of this importance does not, as you can imagine, happen overnight. Today's event is the result of a two-year technical cooperation agreement between the Pan American Health Organization and the American Association of Retired Persons. We are proud of this agreement because it demonstrates the very beneficial results that can be gained through cooperation for both an international organization, such as PAHO, and a national public interest association, such as AARP.

While I am certain that most of you in this room are familiar with the long history and activities of PAHO in the Americas, some of our visitors from abroad may not be familiar with the American Association of Retired Persons. Founded in 1958 by Dr. Ethel Percy Andrus, a retired school teacher from California, AARP has grown into the foremost organization representing the interests of older persons in the United States. (I should also mention that we have some 25,000 members in other countries as well.) We are nonpartisan and do not identify ourselves with either of the two major political parties in this country. We do, however, work hard to develop solutions to the problems facing older persons in the areas of health care, pensions, housing, discriminatory practices based on age, and many other areas that affect the quality of life of older members of society.

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[1] President, American Association of Retired Persons (AARP).

In particular, the AARP Board of Directors has identified the problems of older women as the focus of one of the priority initiatives to be carried out by the Association. Therefore, AARP established the Women's Initiative as the principal resource with both the mandate and the commitment to help women secure a more rewarding future. We are a large and complex organization, so it is necessary to explain that it is the Women's Initiative, through the International Activities Department of AARP and in cooperation with the Pan American Health Organization, that is ultimately responsible for this project and conference. We invite all of you, and particularly our visitors from abroad, to acquaint yourselves with some of the activities carried out by the Women's Initiative to improve the situation of older women in this country.

The Women's Initiative has also been interested in sharing experiences and exchanging information with women from other countries. This activity is being carried out through an international network of researchers, practitioners, and advocates interested in issues affecting older women, the Global Link for Midlife and Older Women. Some of you may be familiar with its newsletter, *Network News*. We hope that one of the outcomes of this meeting will be the establishment of a more cohesive network of researchers and policy makers in the Americas, focusing on the concerns of women at midlife and beyond.

The question has been and will continue to be raised: "Why single out older women for special attention when there is so much to be said regarding the elderly in general, as well as other members of society judged to be particularly vulnerable?"

I do not have the slightest difficulty in responding to this question, because my experiences as an AARP volunteer in my own local community and as national president of the Association have convinced me that there remains so much to learn and understand about women and their lives as mothers, workers, grandmothers, care-givers, and, eventually and often, care recipients. We know that women live longer than men, that those who live alone tend to be among the poorest of the elderly, and that they suffer more from social isolation and chronic diseases than most other members of society. However, we still have a great deal to learn about why this is the case and what we—and those women themselves—can do to improve their lives.

My conviction that we need to devote more attention to issues affecting older women was greatly reinforced when I attended the United Nations Conference on Women in Nairobi in 1985. Many positive things developed from the Nairobi Conference, including the adoption of the Forward-looking Strategies, but you will have to look long and hard before you will find the one paragraph in the Strategies that relates to the concerns of older women.

This Consulting Group Meeting is proof that we in the Americas are ready to correct this oversight. The background report, experts' reports, and the proceedings of this meeting will constitute a valuable foundation for future work on behalf of older women in the Americas.

As an Association, we are deeply committed to promoting the interests of older women in our country. We will continue to speak out on issues of concern to these women, and we look forward to sharing our views and experiences with those of you working on older women's issues in your own countries.

This is, I believe and I hope, the beginning of more frequent and fruitful contacts between North America, South and Central America, and the Caribbean that will lay the foundation for more systematic research on women in later life. I trust that it is also the beginning of a more vocal and enduring dialogue by and for older women, whose voices have never been heard.

Keynote Address

EMPOWERING OLDER WOMEN: AN AGENDA FOR THE '90s

Ambassador Julia Tavares de Alvarez[1]

It is a distinct honor and a great privilege for me to have been invited to this historic and unique meeting.

It is historic because it represents the first time an international organization has joined with a nongovernmental organization to discuss an issue of global importance that is of interest to both of them. I hope this is the first of many such meetings, for such partnerships will strengthen the United Nations as a vehicle for integrating the intellectual resources and the practical experience of the nongovernmental organizations into efforts to meet the demands of the coming years. An article in a UNICEF publication states that nongovernmental organizations "have an essential role to play in the construction of any society or nation. They can be seen as the white corpuscles in the bloodstream. Without their presence, a society can catch all kinds of diseases which make its harmonious development difficult."

This meeting is unique because it includes discussion of women at midlife. This group is a special interest of the AARP's Women's Initiative, which cosponsors an international network of researchers, policy makers, and advocates—the Global Link for Midlife and Older Women—to encourage dialogue on the topic. This is the first international effort to focus specifically on women at midlife and beyond. In addition, this meeting is unique because it deals with one of the most important demographic issues of our time and it does so *before* it has reached crisis proportions. When Ms. Margaret Anstee, the Director of the Center of Social Development and Humanitarian Affairs of the United Nations, was asked to select three priority social issues, she chose aging as one of them, saying, "social policy for the aging is one of the most significant demographic issues of our time and one where foresight now can lead to reduced problems later."

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[1] Alternative Representative to the United Nations, Permanent Mission of the Dominican Republic.

Despite the importance of the topic, there has been a paucity of up-to-date work on aging in the United Nations system. It was not until 10 years after the inclusion of this item on the agenda of the United Nations in 1969 that the United States of America introduced a resolution calling for a World Assembly on Aging. This initiative was a means of drawing worldwide attention to the serious problems besetting a growing proportion of the world's population. It also served to launch an international action program aimed at guaranteeing economic and social security to older persons, and giving them opportunities to contribute to national development. In its resolution 35/129 (December 11, 1980), the UN General Assembly indicated its desire that the World Assembly should also result in societies responding more fully to the socioeconomic implications of the aging of their populations and to the specific needs of older persons. With these mandates in view, the International Plan of Action on Aging was conceived.

After the World Assembly, however, international interest in issues related to aging gradually slackened. Many obstacles, both financial and political, have hindered the implementation of the Plan of Action. In 1985, three years after the Assembly, the "Group of 77" (originally an alliance of 77 developing countries that has now grown to 125 countries) sponsored resolution 40/30 (November 29, 1985). It expressed concern over demographic projections showing that by the year 2025 70% of all persons over 60 years of age would be living in developing countries, which are precisely the ones least prepared to meet the economic and social consequences of this drastic shift in population structure. The resolution stressed that the elderly must be considered an important and necessary element in the development process at all levels within any society.

Until very recently, the United Nations' primary response to aging focused on the needs of the frail and vulnerable elderly. Although some work is now beginning to consider the participation of older persons in development, the system has yet to address such specific policy questions as the implications of an aging population for social services and income distribution, or the positive contributions that older citizens can make to society. In other words, humanitarian considerations have been emphasized while developmental ones have often been neglected.

If work on aging in general has been scarce on the part of the United Nations, the concerns of midlife and older women have been almost completely neglected, particularly in developing countries and, to some extent, also in the industrialized world. Although there have been great strides in improving the status and the well-being of women in general, and some work has been done in the field of aging, little, if any, attention has been paid specifically to the situation of midlife and older women. This is evidenced by the fact that the Vienna Plan of Action on Aging refers to older women almost as an afterthought—in only one sentence embedded in one of its 62 recommendations. A similar neglect is also evident in the Report of the International Conference on Population. Even more surprising is the minimal attention given to older women in developing regions during the United Nations Decade for Women and at the World Conference to Review and Appraise the Achievements of the UN Decade for Women, held in Nairobi in 1985. The official report of the conference, the Forward-looking Strategies, contains only one paragraph on "elderly women," reiterating the recommendation of the International Plan of Action on Aging.

This neglect of the concerns of midlife and elderly women is difficult to understand in light of the fact that the social and economic transformation accompanying an aging society relates, particularly and peculiarly, to women. According to a study done by the Population Crisis Committee, "the feminization of poverty is spreading." Thus, as societies are becoming older, they are becoming increasingly female and poor. In spite of these inequalities and disadvantages, midlife and elderly women play a key role in the developing world. A major and surprising finding in the research done for the background report for this Conference was that women at midlife and older play a key role in both economic development and family stability in Latin America and the Caribbean, far beyond that which would be anticipated by their numbers. This is true to such an extent that, if their productive resources and care-giving roles were suddenly withdrawn and abandoned, the effects on the Region's economy and social structure would be devastating. The report suggests that, in spite of their important roles, women's contributions to society, particularly older women's contributions, continue to be underestimated and go widely unrecognized.

We therefore need to address the question of how we can achieve a greater recognition of older women's productive roles and thereby help them overcome their marginal status in society. With the projected rapid increase in the overall number of the elderly in the developing world, it is inevitable that more attention will have to be paid to their concerns and roles in society. Yet, this does not necessarily mean that Third World countries—with their already severely strained national economies—need to follow the Western model of "retirement from work" as it exists in the industrialized world. In fact, even in the industrialized world we are beginning to see movement away from the "retirement" concept and to observe more emphasis being placed on the overall well-being of the elderly, which includes a recognition of their vital and productive roles in the family and community.

The answer to the question of how to prevent the marginalization of older women may therefore lie, in part, in the simple recognition of the realities of women's lives. Women at midlife and beyond contribute to their families and communities through their roles as family care-givers, health care providers, active (though often uncounted) members of the labor force, community organizers, and volunteers.

How do we achieve this recognition? What should our agenda for the '90s include?

I believe that the first step has in fact been taken by convening this Consulting Group Meeting and the completion of the background report on the situation of midlife and older women in the Latin American and Caribbean Region [see Part I of this book]. The report represents a major step forward because basic data, statistics, and indicators, which quantify the particular disadvantages that midlife and elderly women face in relation to their younger counterparts and delineate their roles in society, can influence public perception, policies, and programs. They can also influence women's own perception of what the future holds for them. I hope that this excellent research paper will serve as a model and an inspiration for further research and cross-national and international studies and data bases.

My first recommendation, then, as we try to prepare an agenda for the '90s is to wage a campaign to convince younger women that if they do not share our efforts today, they will have to begin the struggle anew upon reaching midlife and old age. We must convince them that we are working to build a better future for them, that our struggle is indeed their struggle, that the social, economic, and political inequalities that all women face are compounded for elderly women by the age discrimination that is characteristic of youth-oriented societies. We must convince younger women to form coalitions with older women so that all age groups can benefit from the tremendous strides made by women during the last decade and can enjoy the political influence that older women still lack.

One only has to look at the United Nations system to see the important measures that have been taken by that organization to promote equality for men and women. These include the Commission for the Status of Women, the Convention on the Elimination of Discrimination Against Women, the proclamation of the United Nations Decade for Women, the

International Research and Training Institute for the Advancement of Women (INSTRAW), three international conferences (Mexico City, Copenhagen, and Nairobi), UNIFEM, and the Declaration on the Participation of Women in Promoting International Peace and Cooperation. To this list could be added other measures taken at the international level to promote the welfare of women.

Why have midlife and elderly women been excluded from all the above initiatives? According to former Assistant Secretary General Dr. Robert Muller, "if a sizable global problem like the aging of the world's population had arisen forty years ago, the international community would have undoubtedly created a United Nations specialized agency similar to UNICEF. Having come up only in the late seventies, after the cumulative creation of a large number of specialized agencies and programs, governments were already weary of creating new ones. Compounding this situation was a world economic crisis and the worst financial crisis facing the United Nations since its inception."

Asked if the situation was hopeless under these circumstances, Dr. Muller stated emphatically that it was not, especially, he said, "if one does not continue to pound one's head against the wall of governmental opposition to create new establishments and if, on the contrary, one takes advantage of it." Dr. Muller believes that "the reluctance of governments to enter into new arrangements for international, intergovernmental cooperation opens the door to new forms of international cooperation in which citizens, nongovernmental organizations, and the private sector can play a prominent, unprecedented role." He believes that a "World Foundation for Aging" is a novel idea whose time has come.

The Government of the Dominican Republic has made a request to the Secretary General that the modest resources of the Trust Fund for the Promotion of the United Nations Program on Aging be used to explore the proposal to create a world foundation on aging, which would encourage the private sector to support the work of the United Nations systems in this field. Another option is to use these resources as seed money in the formulation of a concerted program of measures for the year 2000, when more than three-fifths of the world's elderly will be living in developing countries.

The tenth anniversary of the World Assembly on Aging in 1992 presents an ideal occasion for the United Nations and intergovernmental and nongovernmental organizations to launch a worldwide round of activities on aging, involving the media, trade unions, employers' and pensioners' associations, and youth and women's organizations.

We will, in the forthcoming Forty-third General Assembly of the United Nations, request that aging be identified as a priority theme in both the Organization's Medium-term Plan for the period starting in 1992, and in the elaboration of an international development strategy for the fourth development decade (1991–2000). We will continue our struggle, which now dates back almost a decade, to place the aging issue high on the agenda of the United Nations, where it belongs. We are looking forward to the Second Review and Appraisal of the World Plan of Action on Aging, to be undertaken by the Commission for Social Development in its biennial meeting scheduled for February 1989. Resolution 42/51 (November 30, 1987) asked for the establishment of an ad hoc working group of the Commission to carry out the review and appraisal. I am sure this appraisal will show that the Vienna Plan of Action must be updated, taking into consideration the social, economic, and political obstacles that have prevented its adequate implementation. We hope to be able to include recommendations for dealing with the particular problems of midlife and older women. The potential political influence of such a large segment of the population should ensure a negotiation of better terms for elderly women than those currently prevailing—terms meant to open the door to social and economic participation for older women, which ultimately will benefit all aspects of their lives.

It is the intention of the Government of the Dominican Republic to include midlife and elderly women in the Forty-third General Assembly's resolution on the implementation of the Plan of Action on Aging, and to urge the Commission for the Status of Women to pay particular attention to the specific concerns of midlife and elderly women.

In concluding, I would like to congratulate PAHO and AARP for convening this Consulting Group Meeting. It is a vivid illustration of what nongovernmental organizations can do to help the United Nations and its system of agencies in their efforts to build a better world. This pioneering meeting could lead the way to new ventures that will not only identify but channel the tremendous contributions that midlife and older women can make to their societies.

The responsibility rests on those of us women who are in a position to influence policies in our countries to fight for the rights and well-being of the elderly, particularly midlife and elderly women, who have a double jeopardy because they are women and they are old. *Empowering Older Women* should be our agenda for the '90s. Let us fight for our rights. Let us, as Lincoln said, "have faith that right makes might, and in that faith, let us to the end, dare to do our duty, as we understand it."

OCCUPATIONAL HEALTH OF MIDLIFE AND OLDER WOMEN IN LATIN AMERICA AND THE CARIBBEAN

Freda L. Paltiel[1]

> Health for All will only be achieved if the creation and preservation of healthy living and working conditions becomes a central concern in all public policy decisions. In particular, work in all its dimensions—caring work, opportunities for employment, quality of work life—dramatically affects people's health and happiness. Work needs to be explored in terms of its impact on health and equity. . .
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> . . .Women are the primary health promoters the world over, and most of this work is performed without pay or for a minimal wage. The way women's networks and organizations work are models for the process of health promotion organization, planning, and implementation. Women's networks should receive more recognition and support from policy-makers and established institutions. Otherwise, this investment of women's labour serves to increase inequity.
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> *2nd International Conference on Health Promotion, Adelaide, Australia, April, 1988*

This paper explores a field in which there is not a reliable body of knowledge, even in North America. Large-scale occupational health studies have generally excluded women. Instead of a life-cycle approach, including midlife and older women workers, studies of women's exposure to occupational hazards have, appropriately or inappropriately, focused on reproductive outcome; meanwhile, the reproductive consequences of males' exposure to hazards have been largely ignored. One must agree with Vilma Hunt, a leading exponent of women's occupational health, that efforts to protect workers from employment hazards lack a unitary concept (Hunt, 1979).

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[1] MPH; Senior Advisor, Status of Women, Health and Welfare Canada. The views expressed are those of the author and do not necessarily represent those of the Government of Canada or Health and Welfare Canada.

Problems associated with aging in Latin America and the Caribbean also receive too little attention as a focus for public policy, since care of the aged has traditionally been a family matter. Yet Jamaica, Uruguay, Barbados, Cuba, and Argentina have percentages of persons over 60 years of age comparable to those in developed countries. Changes in economic structure, increasing urbanization, greater longevity, lower fertility rates, and loosening of family ties and obligations due to migration and sociocultural changes are forcing these problems onto the public agendas of developing countries in the Region—hence, the importance of agencies like PAHO and nongovernmental organizations like AARP in identifying issues and cost-effective, culturally appropriate strategies to mitigate negative impacts and promote positive societal effects of these demographic changes.

Since about 35% of the Latin American population lives in conditions of relative or extreme poverty, the growing lag between the needs of older persons and the will or capacity to provide for them poses new challenges to development policies and programs. The lack of organizations or political influence of women aged 45 and over, who represent approximately 25% of all adult women in Latin America, has limited their ability to compete for scarce resources; however, their politization is occurring. They have marched for others, now they will march for themselves.

In writing about midlife and older women, one must remember that one is writing about a group affected by the interaction between personal experience and social structure. Hence, there will be a diversity of experiences not only between societies and within societies, based on socioeconomic and cultural differences, but also between age cohorts, who have experienced their midlife and senior years at different times.

An estimated 10 million women in the Commonwealth Caribbean who are over 40 are widowed or were never married, but carry major family responsibilities. In the Commonwealth Caribbean, an estimated 32–40% of households are headed by females. Over 88% of these women have only a primary education, and female heads of households tend to be older than their male counterparts. Indeed, households with a female as the sole economic provider are generally the poorest households. Poverty, inaccessibility of clinics, and long and unpredictable working hours in the informal sector constitute barriers to health care for these women, who are already at higher risk because of nutritional deficits, fatigue, and stress resulting from a lack of resources or support and from their vulnerability to harassment or abuse from many sources. Health services for women have generally focused on maternal and child health. The needs and risks of women beyond childbearing age, particularly in regard to chronic diseases, have received less attention than they require and deserve.

As Canada's focal point in the Women, Health, and Development (WHD) Program, and as a participant in PAHO's development and implementation of the regional forward-looking strategies in this area, I have consistently taken the position that we must not persist in a false dichotomy between developed and developing countries. We must explore the interrelated themes in the lives of women throughout the Region, while focusing specific interventions on the needs of target populations, bearing in mind the most vulnerable groups.

For the developed world, this is a propitious time to focus on the relationship between work and family responsibilities, as governments become alarmed about the "burden" of aging populations and once again see the family as the agency of care. However, as Carol Buck pointed out at the recent National Symposium on Changing Patterns of Health and Disease in Canadian Women, the concepts of community care, self-care, self-help, and social support are attractive, but their development should not be based on the assumption that they will be implemented through the unpaid work of women (Buck, in press). Effective community care will require a solid core of paid workers and adequate physical facilities. But since the need for provision of care by family and community will continue, strategies must be directed to more fairly dividing the work of caring between the sexes, as part of a general restructuring of the social division of labor.

Midlife and older working women in North America who took time out of the labor force to care for families, and thus forfeited earnings and pension entitlements, did so without the benefits of pay equity, child care, maternity benefits, or parental leave provisions, thereby enduring great difficulties in combining work and family responsibilities. Currently, they may be caring for aged parents, their own or their partners', without the requisite community support. Some commentators have noted that Latin American professional and higher status women workers are better off, since they can rely on domestic help; but other writers have noted the lack of solidarity between these high-status women and those who serve them.

LABOR FORCE PARTICIPATION

Rates of female participation in the labor force are substantially higher in the Caribbean than in most Latin American countries, even the newly industrialized countries such as Argentina (with 20% participation), Brazil (28%), Chile (21%), and Mexico (18%). According to Peggy Antrobus, "There has always been a significant percentage of women in employment in the Caribbean. Under slavery, women worked side by side with men in the fields. In fact, in the later period of slavery women outnumbered male workers on the plantations." In Barbados and Jamaica nearly half the labor force is female.

Table 1 reveals the high labor force participation rates of women aged 45–49 in all Caribbean countries and El Salvador, Peru, Uruguay, and Brazil (aged 40–49). The wide variations in employment rates for women over 65 may reflect the differential needs and social security coverage of that age group in different countries.

Women are overrepresented among the unemployed in most countries in Latin America and the Caribbean. Studies have shown that unemployment has profound effects not only on economic status but on mental health of workers and their families. In Barbados, 61% of the unemployed are women, while in Jamaica the figure is 66% and particularly high in rural areas. In Latin America, for comparison, 34% of the unemployed in Argentina are women, 33% in Chile, and 30% in Costa Rica.

Official participation rates tell only part of the story. Antrobus estimated that 70% of Caribbean women are working in low-paid, low-skill, marginal jobs in domestic and other services; most of the rest work in the traditional female occupations of teaching, nursing, and secretarial work. According to the International Labor Organization's *1987 Yearbook*, in Latin America and the Caribbean a very small percentage of positions in administrative and managerial categories are held by women: Bahamas, 25%; Chile, 18%; Ecuador, 16%; Mexico, 15%; Venezuela, 14%. However, educational attainment of girls in the Caribbean is at least equal to that of boys up to secondary level, while at university level, female enrollment is nearly as high as male.

OCCUPATIONAL HEALTH

The health of midlife and older women workers depends upon the context of their sectoral and occupational concentration; their physical, biological, and chemical environment; their work conditions; the processes in

Table 1. Labor force activity rates for females aged 45 and over, in selected Caribbean, Latin American, and North American countries, 1985 and 1986.

	Age (years)						
	45–49	50–54	55–59	60–64	65–69	70–74	75+
CARIBBEAN							
Bahamas	63.5	59.2	49.2	38.0	16.1		
Barbados	73.1	58.0	63.9	28.9	7.2		
Cuba	40.7	30.9	18.1	7.8	3.3	1.3	
Haiti	66.7	61.3	59.2	48.5	55.2	46.6	38.9
St. Christopher & Nevis	49.9	44.5	39.1	29.0	12.8		
Trinidad & Tobago	41.9		33.3	23.1	5.9		
LATIN AMERICA							
Costa Rica	20.9	15.5	11.5	6.9	3.1		
El Salvador	50.0	41.6	35.3	14.9	17.3		
Guatemala	12.8	11.8	10.0	8.5	6.2		
Mexico	29.1	27.5	25.8	24.1	21.1	19.7	15.8
Argentina	30.9	26.1	18.0	9.9	5.2	2.8	1.2
Bolivia	23.6	22.1	19.7	17.2	14.7	13.0	9.8
Brazil	43.5[a]	30.3		10.4			
Chile	36.4	28.7	21.8	10.8	6.7	2.7	
Ecuador	18.9	17.4	15.6	13.1	9.1		
Paraguay	20.7	18.2	15.9	12.7	10.3	7.1	3.8
Peru	54.0	45.6	30.4	33.1	20.4	9.5	
Uruguay	46.6	37.0	25.9	13.2	3.7		
Venezuela	20.6				4.9		
NORTH AMERICA							
Canada	67.0	58.0	45.0	27.0	8.0	4.0	2.0
U.S.A.	69.6	62.0	50.9	32.9	14.1	6.7	2.0

Sources: International Labor Organization, *1987 Yearbook of Labor Statistics;* Statistics Canada, 1986 Census, unpublished data (figures rounded).

[a] Ages 40–49 years.

which they are engaged; and the amount of control they have over their work environments, conditions, and processes. The psychosocial environment at work and at home is also a factor, as is the gender- and age-based allocation of status, role, and rewards. Women continue to bear the major responsibility for family members, within and outside their own households, as well as their general household responsibilities. In developing countries, moreover, diseases affecting the working population (e.g., communicable diseases, parasitic diseases, and malnutrition) may be aggravated or potentiated by occupational hazards to health (World Health Organization, 1982).

Women's concern about the dangers of agricultural, industrial, and consumer exposure to chemicals and toxic substances is growing. The Latin American and Caribbean Women's Health Network, comprising about 450 groups, is disseminating information about some of the toxic components in the chemical products used by women, in order to enable them to better prevent dangerous effects on their health.

An international conference on the effects of working conditions on the health of women workers featured collaborative studies by scientists and trade unions. It was confirmed that jobs for women are concentrated in the service sector (e.g., in offices, hospitals, hotels, shops, and domestic service) and in manufacturing (clothing, textiles, electronics, and food production). Work done by women commonly requires speed, mental and visual concentration, and manual dexterity, and is characterized by immobility and long work days. Factors common to the working conditions of males and females were dust, heat, noise, radiation, solvents, and problems with organization of work and physical discomfort in the work environment.

In manufacturing, intense mental concentration and need for precision and speed were stress-producing factors. In service jobs, elevated rates of cancer were noted for hospital workers, while stress and physical discomfort were associated with video display tube work. In the agro-food sector, it was noted that tobacco workers in Nicaragua face problems related to temperature and ventilation, as well as to work posture, which can lead to varicose veins.

The Brazilian Center of Study for Occupational Health and Human Ecology published a study in 1987 that noted the risks and problems associated with four categories of work in which females predominate:

> *For office personnel*—need for speed, uncomfortable working conditions, poor lighting, climate problems, toxic substances, electromagnetic radiation, repetitive and boring work, and harassment.
>
> *For textile workers*—noise, vibration, faulty machinery, uncomfortable positions, fast rhythm, lint from cotton and synthetic fabrics, and harmful chemicals in dyes and solvents.
>
> *For domestic workers*—low salaries, low status, no social security, no holidays, no accumulated vacations, no time for own interests.
>
> *For rural workers*—long days, temporary work, low wages, inadequate transportation, exposure to microorganisms, exposure to insecticides, noise, exposure to variable climatic conditions, nonionizing radiation, vibration, heavy lifting, insect and animal bites (Tambellini, 1987).

University of Quebec researchers in Montreal found that sex-specific differences in working conditions, not biology, explained the differences between males' and females' health complaints in a study of 661 workers at nine poultry processing plants (Mergler, 1984). Most women had assembly line jobs, standing at conveyer belts for long periods cutting and packaging products with rapid repetitive movements requiring close attention. Men typically worked in jobs (e.g., shipping) that involved moving around and control of their own work pace. Women's work resulted in leg pain, cramps, and swelling in lower extremities. No statistically significant differences occurred in cold exposure.

Agricultural Workers

In PAHO's *Health of Women in the Americas* (1985) the use of highly toxic pesticides is described as "taking on alarming proportions." The (largely female) work force in the agricultural countries of El Salvador and Guatemala experienced 89% of the 19,330 cases of insecticide poisoning recorded in five Central American countries between 1971 and 1976.

Women 40 years old and over form a high percentage of the agricultural labor force. They produce the bulk of the food and sort, pack, transport, process, and distribute it. These women face the risk of poisoning from pesticides used in production as well as from chemical food additives used in processing.

In the Caribbean, women play major roles as farm laborers, heads of farm households, and marketers of agricultural produce, accounting for 30% of the agricultural labor force in Saint Vincent, 47% in Saint Lucia, and over 50% in Montserrat and Antigua. Risks/hardships include low, sex-differentiated wages; seasonal work that may require displacement of family; accidents; exhaustion; lack of access to land equipment and credit; lack of access to information, technology, and training; lack of involvement in wage and working condition negotiations; and lack of representation in policy-making bodies. A double work-load leaves no time for membership in groups that could work to improve the situation.

Where loss of land occurs, older women change from being cultivators to laborers, while with industrialization, younger women move into labor-intensive industries such as electronics and textiles and away from agriculture. In Brazil, where women had once constituted nearly half of all agricultural workers, they represented only one-fifth by 1970.

Animal husbandry is largely the domain of women in Latin America and the Caribbean. They are placed at risk of infection from zoonotic organisms such as brucellae, which can lodge in the human female reproductive tract and can result in tubo-ovarian and pelvic abscesses.

Clearly, more policy research is needed to recognize the role of women in agriculture, their precise tasks, working conditions, and specific risks, as well as their satisfactions and gains. Two Caribbean studies are illuminating women's agricultural involvement: one in Saint Lucia, and the other in St. Vincent and Dominica. In addition to more research, there is a need for more qualified women as agronomists, food technologists, and extension workers.

Industrial Workers

In Latin America, female industrial workers are concentrated in the textile, clothing, footware, food production, electronics, and handicraft industries (PAHO, 1987). During the 1970s, governments of the Region attracted or invited multinational corporations to set up offshore operations known as "export processing zones" (EPZs), which are geographical areas, mainly in developing countries, in which semi- or fully processed goods are manufactured for export. International development agencies encouraged those zones as a means of transferring technology and encouraging exports and industrial development that would create employment and develop management expertise. The EPZs offered tax exemptions and benefits to multinational corporations as well as a pool of inexpensive labor. The industries attracted were mainly textiles, garments, and electronics.

There are currently about 120 EPZs in developing countries in Asia, Latin America, the Caribbean, and Africa. Midlife and older women are effectively excluded from EPZs. About four-fifths of the workers in electronics assembly plants are young, unskilled or semiskilled, generally single women. In São Paulo, Brazil, Saffioti (1983) has described an enormous absorption by textile firms of female workers under the age of 18. The work has been described as monotonous, repetitive manual labor, and reinforces the myth that women are particularly suited to these tasks.

Along the Mexican border, 60% of the EPZs are devoted to electronics, while 30% are textile and garment factories. Recent studies have focused on the implications of these EPZs for women's work, health, and well-being, specifically the aspects of job security, lay-offs and rehiring at beginner's wages, extended trainee periods below minimum wage, long working hours, and piecework and production quotas.

Electronics. Health and safety risks in the electronics industry include fatigue; exposure to dangerous chemicals (acids, solvents, and gases that may cause euphoria, headache, and dizziness); risky processes like soldering, rubber mold casting, spraying, and electroplating; use of metals; and eyestrain. Women workers are also at risk of sexual harassment from managers, and since their jobs are insecure they lack legal or administrative mechanisms to control sexual harassment. Poor living conditions have been reported by women living in dormitories or squatters' huts, while other women must commute long distances from villages or hamlets where they also have family responsibilities. Social security or seniority provisions are rare, two factors of major importance to women in midlife and old age. Wages are often given to mothers or fathers.

Efforts to organize or to gain female representation on bargaining units have met with opposition and occasionally violence. Mothers sometimes must accompany their daughters to work to protect them against harassment or violence, exemplifying the responsibilities carried by midlife women for other workers in their families.

Textiles. The conditions described above contrast markedly with Saffioti's (1983) example of one Brazilian textile firm where, although wages were low, older, more experienced women were retained, the craft production process allowed greater freedom of rhythm and work satisfaction from finished products, and natural socialization was encouraged. All of these are factors that are known to decrease alienation and promote mental health as well as productivity.

In the textile industry, noise frequently exceeding 90 decibels is associated with hearing loss, gastric hypersecretion, cardiovascular problems, and mental health effects. Injurious dust may cause byssinosis (brown lung), and highly dangerous asbestos dust may be released in yarn preparation and spinning.

Textile workers may be exposed to mechanical irritation of the skin due to rough fibers, sewing machines, or exposure to chemicals like acetic acid or other irritants in dyes, resins, bleaches, and softeners. Indeed, skin disorders comprise more than 45% of all occupation-related diseases, of which more than four-fifths are attributable to chemical exposure.

Hunt (1979) cites a retrospective survey revealing that workers in the apparel industry showed a consistently higher relative risk for cancer of female organs—breast, corpus uteri, and cervix uteri. These workers are exposed to chemicals used for dyeing, finishing, mothproofing, flame retardation, and wrinkle resistance.

Migration is another factor salient to occupational health. In the years 1981–1984 the PAHO Member Countries Haiti, Jamaica, Guyana, El Salvador, and the United States were among the top 14 birthplace countries for female immigrants to Canada, accounting for about 17% of all immigrant women. It is estimated that half of textile and almost all clothing industry workers in Canada are immigrant women. Their work is often characterized by relatively low wages (including piecework rates), unpredictable hours, and difficult working conditions. The annual turnover rate is about 35%. Among workers who receive piecework wages, high incidences of stomach ulcers and tranquilizer use have been reported. Language barriers and underutilization of the health care system are problems receiving increasing policy attention.

Handicrafts. Particularly in the jewelry industry, handicrafts have a high concentration of women employees, who often work in enclosed areas. The work is labor-intensive, characterized by piecework, and includes processes such as electroplating, buffing, grinding, soldering, and glueing that carry disparate and cumulative risks. Chromium used in the manufacture of ceramics is a suspected carcinogen.

Hazardous Materials. The importance of lead in relation to women's occupational health has been a very controversial topic, since women have been excluded from higher paying industrial jobs where lead exposure is a factor. However, a lead-zinc alloy is used in soldering components in electronics assembly work where women are heavily employed.

Hunt (1979) points out that there appear to be no marked demographic differences between workers exposed to lead and those exposed to benzene, an extremely toxic substance used in industrial processes in which many women are engaged and where efforts have been directed towards substitution rather than discriminatory female exclusion. Benzene, which is a powerful solvent, is used in the manufacture and processing of synthetic rubber, paints, varnishes, adhesives, and sealants, and is contained in gasoline. Workplace exposure has the potential to cause blood disorders, anemia, bone marrow diseases, and leukemia. It tends to migrate to fatty tissues, and protracted chronic exposure may be fatal. Vaginal bleeding is one symptom of severe benzene poisoning.

Workers in synthetic rubber manufacture, the boot and shoe industry, artificial leather production, color photographic printing, and dry cleaning may be exposed to benzene used as a solvent or diluent. Even where its use is declining, it is still present in trace concentrations in many solvents that have replaced it and in the environment as a result of automobile exhaust and cigarette smoke.

Control of a hazardous substance such as benzene in the workplace requires process changes, enclosure or isolation of emission sources, ventilation, leakage control, safe work and hygiene practices (especially not smoking or eating in the site of work), administrative controls (such as reassignment of exposed personnel), personal protective equipment, and, above all, clear public policy.

A pan-Canadian system, the Workplace Hazardous Materials Information System (WHMIS), is designed to protect Canadian workers by providing them and their employers with vital information about hazardous materials used in the workplace. The key elements of the regulations and the act are the establishment of criteria to identify hazardous substances, the cautionary labeling of hazardous products, the provision of material safety data sheets, and the establishment of criteria for evaluating confidential business information claims.

SERVICE SECTOR

In the Caribbean, where women comprise 35–40% of the work force, they represent between half and two-thirds of service workers. Government is the largest employer, with women comprising 22–28% of government workers. While a minority have risen to senior administrative categories, most female service workers are concentrated at the lowest levels, in the hotel and restaurant industry and self-employed as seamstresses, hairdressers, and petty merchants.

Commerce. Many of the female self-employed service workers are outside the protection of laws concerning working conditions, such as those regulating hours, pay, social security, or occupational health standards. Babb (1984), describing women involved in petty commerce in Peru (comprising 99% of retail activity), calls for better inquiry into and analysis of the lives of people in these marginalized economic sectors. As development moves in the direction of capital-intensive industrialization, those who are marginalized or displaced must subsist on outwork, piecework, or commission, or trading products supplied by wholesalers. While the ranks of women who work at home are increasing, most women take their services, such as laundering, cleaning, sewing, and food preparation, out of the home into the marketplace as vendors or domestic servants. Their work is underreported, since it is considered unproductive and informal.

As street vendors, holders of market stalls, or island-hopping merchants, women traders play key roles in marketing of agricultural products and crafts and souvenirs. They also act as distributors for male wholesalers or sell the wares they and their neighbors have produced. In Jamaica and other Caribbean countries, examples of very successful higglers who have amassed wealth and position are frequently noted, but such women are a small minority. In instances where these women have organized into cooperative or other organizations, they have increased their access to credit, influenced market conditions, and gained bargaining power with wholesalers and government authorities. But too many women still move between a shack called home and a cart or booth called workplace to support themselves and their dependents.

Health sector. In the health sector large numbers of women work as technicians in hospitals and biological and chemical laboratories. They are engaged extensively in processes involving organic compounds. Hunt (1979) calls these "unhealthy places of employment" and notes that there are virtually no epidemiologic studies of women laboratory workers.

Nurses everywhere are at risk not only from exposure to biological and chemical toxic substances, but also from stress due to work overload and a status incongruent to the heavy responsibilities for patient care that they bear. In many instances they lack authority commensurate with those responsibilities; older nurses may chafe under the authority of much younger medical supervisors. High rates of smoking and access to drugs place nurses at additional risk arising from unhealthy coping behavior.

Occupational radiation exposure may occur in the health sector. Individual monitoring through film badges and other dosimeters is considered standard practice. Hunt (1979) found confirmatory evidence of effects of ionizing radiation on breast tissue, and urges procedures such as greater precautionary use of lead aprons, closer monitoring, and more refined operating practices.

AIDS (acquired immunodeficiency syndrome) is caused by a virus that weakens the body's immune system, compromising its ability to fight infectious diseases and certain cancers. It is not spread by casual contact. Health care workers whose work involves contact with patients, their blood, other body fluids, or tissues should intensify protective and preventive procedures for dealing with infectious diseases and handling contaminated materials.

Child care. These workers, who are typically undervalued and underpaid, are exposed to infectious diseases and toxic substances in craft materials, and run the risk of physical injuries due to carrying children, bending, and lifting. They are also affected by the stress involved in caring for children.

Social welfare. Workers in this field are at risk for stress and burnout, as they must continuously battle difficult, often intractible social problems with scant resources, and must regularly witness persons returning to the adverse socioeconomic conditions and psychosocial environments that caused the problems in the first place.

Office. While office workers are "elite," compared with manual workers, whose work is harsh, dirty, and dangerous, the Stellman/Columbia Study (Stellman, 1983) found that office workers had very little control over their physical environments: one-third could not decorate their work space; 90% could not control traffic around their desk; four-fifths were constantly in view of others and had no privacy or control over privacy of conversation; and the same proportion could not alter ventilation or change ambient temperature. In addition to stress, other occupational hazards include dermatitis caused by newsprint, adhesives, cleaners, ink, fluid, and solvents.

Video display terminals (VDT) are an ever-present feature of the modern office. The potential threats to human health that have received attention stem from radiation, a physically uncomfortable worksite, stress, skin disorders, and effects on eyesight. Blurred vision, eyestrain, and headaches may be more pronounced in persons over age 40, who may require visual correction. Musculoskeletal complaints are more common among VDT workers than among other office workers; repetitive tasks, immobility, machine pacing, poor design of desk or chairs, equipment and lighting are factors. Rest periods and task differentiation, better design of worksite, lighting, and ventilation, and control over work organization and conditions favor improved health for VDT users.

A new regional phenomenon that bears mentioning from an occupational health perspective has been termed "the electronic sweatshop." Currently, at least 12 U.S. firms have data processing operations in the Caribbean: seven in Barbados that have invested in telecommunications, at least three in Jamaica, and one each in St. Kitts-Nevis and Haiti. Clerks in the Caribbean earn US$15 to US$60 per week, about one-sixth the equivalent pay rate in the United States. Data entry is one of the most labor-intensive phases of data processing, and young women comprise 99% of these workers. It has been predicted that there will be more of this type of enterprise in the next 20 years; alternately, it is forecast that continuing innovations in technology, such as machine reading, will make this job obsolete.

Hair-dressers and cosmetologists. These women show higher relative risk for cancer of the corpus uteri and very high relative risk for ovarian cancer, two comparatively rare cancers.

Domestic work. Whether paid or unpaid, this work is viewed as "non-work," is assigned a negative, often demeaning status, and is usually ignored in occupational health studies. The Housewife Association of Trinidad and Tobago (HATT) found in 1975 that over 40% of domestic workers worked more than eight hours per day, and sleep-in workers sometimes more than twelve. Domestic workers are rarely given maternity benefits or protection against sickness and old age disability. Low wages make it impossible for them to make adequate provision for their own health and social security. For the majority, wages and other conditions of work are determined in private agreements between employer and employee, with benefits, if any, depending on the employer's generosity.

In the 1975 HATT survey, domestic workers complained of inadequate living and sleeping accommodations and improper and discourteous modes of address from employers and their offspring. Employers complained of dissatisfaction with the kinds of services provided by domestic workers and the abuse of privileges extended to them.

Migrant work. A substantial number of migrant women enter Canada as temporary workers. In 1979-1980 over 200,000 employment authorization permits were issued to women. Most of these women came from the Caribbean, Europe, and the Philippines. Since 1981, following the expression of considerable concern by women immigrants advocacy groups about the condition of domestic workers, a Foreign Domestic Worker program was established to curb exploitation and to enable these workers to acquire permanent resident status after meeting certain requirements.

Cleaning and sweeping. Those who do this work in health institutions, schools, and factories are often midlife or older women with little or no schooling. They are exposed to chemical solvents in cleaning materials and to waste products. Where those factors are combined with such conditions as low education and income, poor knowledge of hygiene, and low nutritional status, these persons are at elevated risk. Adult literacy programs that incorporate health information would clearly benefit them.

Occupation grandmother. It is not uncommon in the Caribbean for women to raise two generations of children, often without a partner. Many mothers go to work in cities or migrate to North America where they become domestic servants or nannies caring for others' children; their own are left behind with grandmothers, generally in a rural environment. The specific needs, risks, and tasks of these midlife and older women merit systematic attention within the context of occupational health. They have bonds of affection with their grandchildren, but they also bear heavy child-care responsibilities, without concomitant authority. Their traditional values, customs, and habits may clash with those of their "modern" children and with the "scientific" precepts and demands of health care workers, constituting a source of stress. Their needs for social and income security may be only precariously met, and when the mothers are able to send for their children, these women are frequently abandoned to fend for themselves in old age.

CONCLUSION

I cannot conclude this paper without reference to the role of the media in women, health, and development initiatives. Women employed in the electronic media are powerful role models. We need more of them, specifically midlife and older women, but we need also to ensure that they are equipped with the messages and strategies of the Nairobi conference,[2] in order to promote the health and well-being of women and raise the image and valuation of women's work in society. Health authorities are underutilizing the radio for health messages, which could be beamed directly to workplaces and community centers. NGOs should be accorded wider access to publicly supported broadcast media, and health authorities should equip them with knowledge about reducing both behavioral and environmental risks.

Work site health programs for women should address not only the negative aspects of exposure and risks, but should seize opportunities for health promotion and morbidity control in the environments where midlife women spend the greatest part of their days. Public transportation to and from work also provides opportunities for health promotion messages, which would balance the publicity exhorting women to smoke, drink, and use particular cosmetics or self-medication. Women should avoid eating, drinking, smoking, or application of cosmetics at work sites.

Joint occupational health and safety committees can be formed to engage in pollution control, accident prevention, and health and safety promotion. As women in the Region between the ages of 50 and 69 show the highest incidence of cancers of the cervix and the breast, cervical and breast cancer control programs could be introduced into workplaces with high concentrations of women workers. Diabetes and osteoporosis control and education can also be carried out in the workplace, as well as blood pressure monitoring and obesity reduction. Family violence prevention and control and age- and sex-appropriate fitness and nutrition programs may be introduced. Smoking cessation programs and substance abuse programs designed for women can also be effectively carried out in the workplace. Such low-cost/high-payoff programs have a multiplier effect, as workers exposed to them may influence family and neighbors.

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[2] World Conference to Review and Appraise the Achievements of the UN Decade for Women, 1985.

These measures are not substitutes for reliable data collection systems, well-enforced legislation to protect the health and environment of workers, or workers' compensation, but they are complementary. All such actions promote safe and healthy environments, heighten social responsibility of industry and trade unions, and encourage enlightened self-help and mutual aid of working women of all ages—an essential component of health for all.

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PERCEPTION AND DIAGNOSIS: TWO ASPECTS OF CHRONIC DISEASE IN THE MIDLIFE WOMAN IN URUGUAY

Nelly Niedworok[1]

Today's Uruguayan society features demographic and social characteristics that distinguish it from the rest of the Region and that are a result of the modernization process begun in the early decades of this century. Among demographic variables of special interest are the low mortality and the relatively sharp increase in the age structure that have tended to occur in the intervening period. Both aspects are reflected not only in the relative importance of endogenous and degenerative diseases as a cause of mortality, but also in the high percentage of the population that experiences chronic illnesses.

Such characteristics represent an important health problem in Uruguay today, within the context of deteriorating standards of living and health care resulting from the long period of economic stagnation that began in the 1950s and reached unbelievably serious levels with the crisis of the 1970s.

A first empirical approximation to the study of the problem of the prevalence of perceived chronic disease among the population of Uruguay today (Ministry of Public Health, 1984a and 1984b)[2] allows us not only to quantify it, but also to provide a more detailed descriptive foundation based on the observation of a series of differences by sex, age, and various socioeconomic characteristics.

By quantifying the perception of different types of chronic disease, we confirmed the importance assigned to it by many clinical studies of partial populations, as well as that which is reflected indirectly in mortality trends. We were also able to substantiate the high cost to both society and the individual of morbidity from these diseases, due to both their disabling consequences and to the demand they generate for services and drugs.

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[1] Ministry of Public Health, Montevideo, Uruguay.

[2] Survey carried out in 1982.

Of special interest in this context is the central role of women, since they are—from adolescence and at all ages—the largest group to perceive chronic illness, seek medical consultation, and consume drugs (Ministry of Health, 1984c).

In view of the foregoing, policy direction and, in the final analysis, the elucidation of the "preventable" nature and degree of this situation are difficult tasks whose basic limitations with regard to theoretical and empirical knowledge are particularly important.

There is a "vacuum" in the state-of-the-art regarding this type of nontransmissible disease with respect to the intricate complex of relations among health, morbidity, and fatal outcome of an illness, on the one hand, and its social, cultural, behavioral, and biological aspects, on the other.

In approaching this task, it is clear that a distinction must be made between those social aspects that refer to social stratification and those that are linked to gender differentiation, and the interrelationships among them must also be distinguished.

The specific processes of change that the woman experiences at a physiological level—particularly during midlife—marked by profound repercussions and interrelationships with regard to her place in the family and society, permit an *a priori* assumption of the existence of factors related to gender differentiation that will carry significant explanatory weight.

It is contended that a woman's problems all become more acute after menopause. The loss of the reproductive role and the next stages of the life cycle, marked by widowhood and a distancing from her children, give the woman a sense of "emptiness" in relation to the central socially assigned roles of wife and mother. All this is accompanied by a natural process of aging that slowly takes away the social status accorded to young, sexually attractive women.

It is said that, from this point on, "the lack of power and knowledge, self-deprecation, the loss of self-esteem, dependence, insecurity, and the lack of independence all become more acute, while depression, loneliness, isolation, and mental and physical diseases are produced" (Ibarlucia, undated).

It is known that this process takes on different meanings in societies depending on the age that defines the different stages of the life cycle and their amplitude, demographic characteristics (marriage, fertility, mortality), and also the level of development reached by the specific society. This determines the opportunities that women will have to participate in public life and the generation of new private roles, permeated by other cultural decisions that define the meaning and the values assigned to these stages of the woman's life cycle in different social strata (Ware, 1981).

The cases we analyze come from the city of Montevideo, which has the highest concentration of the aged of any demographic area in the country. They can be characterized as belonging to a society of "Western" culture, where women early acquired important formal rights through legislation and have had access to educational levels similar to those of men. However, women's real participation in society has in many ways been profoundly unequal: they have enjoyed little or no political participation at the decision-making level, and have experienced the inequitable distribution by sex of occupations and hierarchies in economic activity, which reveal a concentration of women in lower-level and less prestigious activities and in "female" occupations. This is associated with the resulting total inequity in employment income between men and women as well as a greater likelihood of unemployment and exploitation, and—in some occupations—the effective lack of legal protection (domestic service, street vendors, work in the home, etc.) (Concertación Nacional Programática, 1985).

Privately, and due to, among other things, their massive entry into economic activity and the decreasing extent and effectiveness of social policies, most women must face more emphatic forms of discrimination in the domestic arena. This means new responsibilities and obligations, since the roles that were traditionally assigned to them by family and society are not reassessed.

With regard to family life, the Uruguayan woman shares characteristics with women in societies with low fertility rates, where the cycle of reproduction and child-rearing is completed relatively early.

MATERIALS AND METHODS

The information analyzed here comes from special tabulations of a survey done on a representative sample of persons 45 years of age and older in the city of Montevideo (number of women = 1,871) and from the clinical protocol completed by means of a medical examination done on a subsample (number of women = 699).[3]

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[3] Estudio de Enfermedades Crónicas y Ancianos. This study was done by the Ministry of Public Health with the technical and financial support of PAHO/WHO.

In this context, we explore the self-perception and diagnosis of chronic diseases and the demand for medical consultation on the part of women between 45 and 59 years of age, with relation to different individual characteristics considered as approximate indicators of their place in the family and society.

These variables can be broken down into two groups: those that refer to a person's place within a vertical social stratification, and those that concern different gender-specific conditions.

For the first group we use per capita family income and level of education. The second group includes position within the home (head-of-house, wife, mother, mother-in-law, etc.), marital status, size of household, relations with family, social participation, and principal activity carried out for most of the person's life.[4]

The analysis focuses on the age stratum defined as "midlife." As was previously pointed out, we propose to observe the relation between the aforementioned variables and self-perception of chronic illnesses, as well as the diagnosed prevalence of these illnesses and their mutual relations, assumed as dependent variables.[5]

RESULTS AND DISCUSSION

As can be observed in Table 1, 69% of the women surveyed defined themselves as chronically ill based on their perception of some specific disease of this type. Furthermore, a similar percentage was diagnosed as effectively having these diseases.

The close similarity in percentages is, however, misleading, since the two groups are not exactly the same, and there are areas of significant disagreement between perception and actual affliction with a disease.

Of those diagnosed as "healthy" in the medical examination, 44.5% perceived themselves as "chronically ill." Similarly, of those diagnosed as having a chronic disease, 20.8% were not previously aware of the disease.

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[4] The variables used were selected from those studied in the aforementioned survey, which was not specifically designed for the objectives pursued herein.

[5] The study on which this analysis is based contained two lines of inquiry that permitted this comparison. The first was a home survey of a sample of persons in which their self-perception of specific chronic diseases was recorded; in the second, a specific diagnosis of the presence of said diseases was made by means of specialized medical examinations of a subsample of persons. See the postscript for more detail on the concrete characteristics and limitations of this study.

Table 1. Variables analyzed in the study of perception and diagnosis of chronic diseases in women between 45 and 59 years of age, Uruguay.

Variable	H[a]	DNP[b]	DP[c]	D[d]
Education				
Without education	(50.0)	(9.1)	76.5	64.7
Primary	49.2	21.6	70.5	73.0
Secondary	44.0	20.7	68.7	69.9
Teacher's certificate	(40.4)	(40.0)	53.3	66.7
University	(11.1)	—	55.6	50.0
Income				
Low	50.0	17.8	72.6	70.2
Medium	38.5	23.2	64.6	68.3
High	43.5	22.4	67.9	71.6
Activity most of one's life				
Did not work	51.7	21.0	73.4	79.7
Domestic service	61.9	14.3	76.8	62.5
Manual labor	48.0	20.0	70.0	68.8
Nonmanual occupation	25.7	24.6	57.3	63.6
Marital status				
Single	(28.6)	(26.7)	59.1	68.2
Married/Living together	52.7	19.7	72.5	71.8
Divorced/Separated	41.7	30.3	62.2	73.3
Widow	17.6	(13.3)	61.7	63.8
Size of household				
1 person	(28.6)	(30.8)	55.0	65.0
2 persons	65.0	13.6	81.4	76.8
3–4 persons	41.2	22.2	67.2	71.2
5 or more persons	40.6	23.0	64.5	65.6
Position within the household				
Head	28.6	23.7	60.9	67.8
Spouse	50.7	19.4	72.4	72.4
Mother/Mother-in-law	(66.7)	(22.2)	75.0	75.0
Other	(50.0)	(20.0)	68.8	62.5
Relations with family				
—those with spouse or companion				
Lives with them	35.0	21.7	65.2	69.7
Frequent	(50.0)	(14.3)	77.8	77.8
Sporadic or none	—	—	—	(100.0)
Has no relations	(18.2)	26.3	53.3	63.3
—those without spouse or companion				
Lives with them	46.7	22.0	68.7	70.2
Frequent	(55.6)	(11.5)	80.0	74.3
Sporadic or none	(50.0)	(25.0)	66.7	66.7
Has no relations	(83.3)	(10.5)	88.0	76.0

Table 1. (Continued)

Variable	H[a]	DNP[b]	DP[c]	D[d]
Social participation				
Does not participate	49.4	20.9	70.7	71.8
Group of friends	42.9	25.0	64.3	66.7
Social club	(33.3)	(14.3)	65.2	60.9
Religious groups	—	(20.0)	60.0	75.0
Others	(33.3)	(12.5)	72.7	72.7
All women	44.5	20.8	69.0	70.6

[a] H = percentage of healthy women who perceive themselves to have a chronic disease.
[b] DNP = percentage of sick women who do not perceive themselves to have a chronic disease.
[c] DP = percentage of women who perceive themselves to have a chronic disease.
[d] D = percentage of women who suffer from a chronic disease.

The interpretation of these inconsistencies is not the same in each case, nor is it simple. The lack of perception of a disease actually suffered would basically depend on the concept of health versus illness and indirectly on the factors that influence that concept. Among these can be mentioned the type of disease suffered and its symptoms, the degree to which it impedes daily activities, and the level of personal health care it requires (Sweetser, 1960).

The consequences of this situation do not raise serious misgivings so long as the diagnosis and early treatment of chronic diseases is recognized as essential for their cure or the prevention of irreparable damage

On the contrary, the perception of a nonexistent disease (as measured by means of a study such as the one we are using as a basis for thiswork) probably presents us with another type of problem, related to the presence of a hypochondriacal neurosis whose seriousness we do not consider ourselves qualified to judge.

For the inquiry we propose that both types of inconsistencies, together with the percentages of the actual prevalence of chronic diseases, must be analyzed as dependent variables in the aforementioned relationship.

Table 1 shows that among the stratification variables considered (education and per capita family income), the former is the one that most clearly accounts for inequality with respect to this kind of disease. The diagnosed prevalence of chronic illnesses is clearly negatively associated with the level of education achieved (except for those in the small stratum "without education").

On the contrary, for income the relation is not so clear, since there is no marked difference between categories nor evident association.

The relationship of the inconsistency between perception and diagnosis to the variables of income and education is unexpected. The women at the lowest income levels show the lowest percentage of ignorance of the disease they suffer, while significantly higher rates are observed among the middle and upper class. At the same time, the lower income group has the highest percentage of healthy women who perceive themselves to be ill.

Among the variables that define the different situations of women in society and within the family, we should point out the variations observed with respect to "activity carried out for most of one's life"[6] and "marital status."

Women who did not carry out any economic activity showed the highest prevalence of chronic diseases. In contrast, those in domestic service had lower percentages, even compared to women who performed other manual labor.

With regard to "marital status," those in the category "divorced and separated" suffered the most illnesses, followed by those who were married.

Here also, the inconsistencies between self-perception and diagnosis show suggestive differences. The group of women who had carried out "nonmanual" economic activities for most of their lives included the highest percentages of women who had a chronic disease but did not know it. The group that had been in "domestic service," on the other hand, included the highest percentages of those who mistakenly perceived themselves to be ill.

With regard to marital status, the married women were more likely to perceive an illness that was not confirmed by diagnosis, while nonperception of a chronic disease was more likely among the "divorced and separated."

Other variables studied in the group of women between 45 and 59 years of age, such as "position within the home" or "size of household," are strongly associated with "marital status," which has already been analyzed.[7]

However, with regard to "size of household," the high prevalence of chronic diseases among women in "two-person homes" is noteworthy, as is the high rate of perception of nonexistent diseases. Seventy-one percent of the women who live in such households are married; therefore, this situation probably reflects particularly those women who are in the "empty nest" stage of life.

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[6] Although this cannot be strictly considered a variable of social stratification, it is strongly associated with income and thus reflects social status.

[7] Chi-square (size of household × marital status) = 65.4624/DF = 9/Probability = 0.000; Chi-square (position within the home × marital status) = 359.804/DF = 9/Probability = 0.000.

With respect to "relations with family" and "social participation," these variables must specify the "quality" of the relation or participation (which has been demonstrated to be the most important aspect), or the possible relationships among the variables remain unclear. With this restriction in mind, it can be pointed out that the highest percentages of those with illnesses are those who "have a spouse and maintain frequent relations with the family" as well as those "without spouse or relatives." Regarding "social participation," those who participate in "religious groups" stand out as having the most chronic diseases. We believe that in both cases these possibly spurious relationships should be eliminated before definitive conclusions are drawn.

Lastly, to illustrate in part how the problem previously analyzed affects the health sector, it is interesting to examine some aspects of the demand for medical consultation. The perception of disease is, as might be expected, the main determinant of the demand for medical consultation, both when consultation is sought for illness and when it is carried out as part of a voluntary checkup.

Perception particularly increases demand in the former case, especially increasing the percentage of those who demand medical consultation. Secondly, the actual existence of a chronic disease (even when it is not perceived) also increases demand, particularly when the woman states she had the medical consultation because she felt ill.

CONCLUSIONS

These conclusions are not presented as definitive since what we attempted here was a simple investigation. It is hoped that this research will suggest new hypotheses in the complex task of pinpointing the social components that explain the actual suffering of midlife women from chronic diseases and the inconsistencies between perception and diagnosis, either as nonperception of disease or a syndrome that may reflect hypochondria.

These three aspects of the problem—actual disease prevalence, nonperception, and false perception—are of direct concern to the health sector for the following reasons:

- The first refers to the actual prevalence of chronic diseases in the population and their known consequences.
- The second exacerbates the problem since it means delayed awareness of and care for these diseases, with a consequent increase in the number of disabilities and need for more complex subsequent treatment.

- The third is important because it would in itself point to the possibility of a neurosis prevalent among a large part of the population studied—with the real suffering this involves—and also because, as has been seen, it is reflected in an increased demand for medical care that may not be attending to the real origins of the problem.

From this brief analysis, we can say that the problems previously pointed out among midlife women in Montevideo show significant differences when analyzed with respect to variables that indicate differences in both place within the social stratification and gender-specific condition in the family and in society.

Postscript

Our analysis is based on a subsample of the women surveyed who also underwent a medical examination. Although we tried to keep the subsample representative of the original sample, in practice it contains some biases that should be kept in mind.

As can be seen from the figures in Table 2, women who perceive some

Table 2. Levels of education, life activity, and income of women in survey sample and subsample.

Variable	% Sample (N = 889)	% Subsample (N = 376)
Education	100.0	100.0
No education	4.5	4.6
Primary	61.0	64.4
Secondary	25.8	22.2
Teacher's certificate	3.3	4.0
University	5.4	4.8
Life activity	100.0	100.0
Did not work	43.2	41.9
Domestic service	12.7	21.0
Manual labor	18.4	24.0
Nonmanual occupation	25.7	13.1
Income		
Low	47.7	50.7
Medium	24.2	24.8
High	28.1	24.5
% perceiving themselves to have a chronic disease	62.5	69.0

chronic disease are overrepresented in the subsample, as are those from groups with less education and income and those who perform manual economic activities (including domestic work).

We believe that these biases, which limit the total representativity of the subsample, do not have an important effect on the analysis undertaken herein.

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MORBIDITY AND MORTALITY OF MIDLIFE WOMEN IN ARGENTINA

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This paper analyzes the situation of midlife and older women in Argentina, where the population has been tending to get older for several decades.

Determining when midlife or middle age begins is difficult and relative. In this case we will consider middle age to be between 50 and 64 years, because in Argentina reproduction at older ages, that is, in women older than 35 years, has been an increasing reality since 1970; therefore, only from 50 years on do problems related with reproduction disappear. In midlife and at older ages, health problems related to aging, not reproduction, are of interest.

Between 1970 and 1980, the increase in the 50 and over population was greater among women than among men (Table 1). If midlife (50 to 64 years) is distinguished from old age (65 years and over), it is clear that the latter group has increased more. If this growth is projected to the year 2000, there will be no increase in the midlife population, but there will be an increase in the population of 65 and over, which will be greater for women than for men.

The geographic distribution of the midlife and over 65 population is not the same throughout the country. The largest proportions of these population groups are concentrated in the country's central provinces, which are the most developed areas. Smaller proportions live in the provinces near the mountains and in the north. The smallest percentages are in the country's southern or Patagonian provinces, characterized by consid-

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Table 1. Population percentages by age and sex, Argentina, 1970, 1980, and projections for 2000.

	1970		1980		2000	
Sex	50–64 years old	65+ years old	50–64 years old	65+ years old	50–64 years old	65+ years old
Men	12.8	5.2	13.1	7.2	12.4	8.1
Women	12.1	5.8	13.5	9.2	13.0	11.1

erable population growth in the last two decades due to the internal migration of young people from other areas or provinces.

If this trend continues until the year 2000, the aging of the Argentine population will increase; it is estimated that 20.5% of the men and 24.1% of the women will be at least 50 years of age. If this is the case, by the year 2000 one of every five men and one of every four women will be over 50. This means that in 12 years, morbidity and mortality characteristics and, consequently, the population's social and health needs will have changed significantly. Therefore it is necessary to begin now some activities and studies that will enable us to gradually improve both social and health services. It is also necessary to educate the population about these matters so that they will begin to think about them and make appropriate adaptations, since before long it will be necessary to make individual and collective decisions that will affect this group.

Although economic activity of those 14 and over is much greater among males than females, since 1960 there has been a trend of increase among women and of decrease among men (Table 2).

An analysis of the economically active female population since 1950 shows that the increase is due to activity among the 25 to 54 age group. Among the groups at either end (14 to 24 and 55 years and over), women's participation in economic activity decreased.

The distribution of the non-economically active population changed

Table 2. Percentage of economically active population 14 years of age and older, by sex, Argentina, 1960, 1970, and 1980.

Sex	1960	1970	1980
Men	84	81	75
Women	23	27	27

during these decades: the percentage of those who do only housework decreased—from 74% in 1950 to 55% in 1980—while the percentage of retired people increased from 12% to 20%, and the percentage of students went up from 10% to 15%. These changes did not affect men and women alike since the decline in those who do only housework was principally due to the increase in economic activity of women between 25 and 54 years of age. The relative increase in retired people and students was more equally distributed among men and women.

This change in the economic activity of women, especially among young and midlife women, has not been accompanied by similar changes in responsibility for housework and children—tasks that still basically fall to women. This means that women are overloaded with work and can be considered to bear a double workload, since domestic chores are added to the activity performed outside the home.

Another interesting point to analyze is the evolution in the type of households or families where people in midlife and those over 65 live, as evidence of the existing types of living arrangements. We only have these data on the population 65 and over in this country. In 1980, 43.1% of older persons lived in extended homes, that is, those composed of relatives extending to the fourth level of kinship. Some 33.4% lived in nuclear families composed of parents and children. Those living alone made up 12%; more of these were women (14.6%) than men (8.3%). Some 8.5% lived in homes where unrelated persons lived together. This indicates that elderly persons still live in family groups where they receive care and can help with domestic tasks as well. Although the percentage of those who live alone remains low, it is greater among women, which indicates a different and more complex problem about care in the case of illness or disability. For now, women living alone are concentrated in the large cities and among the higher income groups.

We pointed out earlier the increase in fertility in the country among women 35 and over between 1970 and 1980, which reached 120% among women from 45 to 49 years of age (Table 3). If this trend persists, not only will high-risk pregnancies increase, but living arrangements will change as well, as maternal responsibilities increase among women during midlife. This will affect women who are economically active differently from those who are not. According to census data, in 1980 the average number of children per woman was higher among those who were not economically active, and it increased with age (Table 4).

In order to analyze the health problems of women 50 and over we will use mortality and morbidity data, although the latter are more relative and difficult to find out.

Between 1970 and 1983, overall female mortality increased. An analy-

Table 3. Fertility rates per 1,000 population, by age, Argentina, 1960, 1970, and 1980.

Age group	1960	1970	1980	% change 1960-1970	% change 1970-1980
All	93	91	95	—	—
15-19 years	56	76	57	+35.7	-25.0
20-24 years	162	147	152	-9.3	+3.4
25-29 years	166	160	175	-3.6	+9.4
30-34 years	118	112	134	-5.1	+19.6
35-39 years	68	54	83	-20.6	+53.7
40-44 years	28	25	33	-10.7	+32.0
45-49 years	5	5	11	0	+120.0

Table 4. Average number of children per economically active and inactive older women, by age, Argentina, 1980.

	Average number of children per woman	
Age group	Economically active	Inactive
All 60 and older	2.3	2.9
60-64 years	2.3	2.8
65-69 years	2.4	2.8
70-74 years	2.2	2.9
75+ years	2.4	3.3

sis by age group shows a decrease among all groups except those 65 and over (Table 5).

An analysis of the male death rate versus that of females between 1950 and 1980 shows that it increased in all age groups, with the greatest differences, that is, the highest male/female ratios, in the midlife age group (50-64 years). In 1980, almost three men between 45 and 69 years of age died for every woman in that age group who died. At 70 years of age and over, the ratio fell to 1.3 to 1.

If we consider proportional mortality by age group between 1970 and 1980, we see a concentration of deaths in persons 65 and over. This is more evident among women than among men (Table 6).

This change in mortality is expressed in an increase in life expectancy at birth that is more notable and persistent among women than among men, mainly due to the significant decrease in infant and child mortality (Table 7).

Table 5. Mortality rates per 1,000 women, by age group, Argentina, 1970, 1980, and 1983.

Age group	1970	1980	1983
All ages	7.0	7.2	7.5
Less than 1 year	57.5	29.6	26.2
1-4 years	3.1	1.5	1.2
5-14 years	0.6	0.4	0.4
15-49 years	2.4	1.6	1.5
50-64 years	9.7	8.2	8.1
65+ years	50.2	48.7	50.5

Table 6. Mortality by age and sex, Argentina, 1970 and 1980.

	Both sexes		Men		Women	
Age group	1970	1980	1970	1980	1970	1980
Less than 5 years	16.7	11.4	15.4	11.4	18.6	11.8
5-44 years	12.4	9.6	13.2	10.4	11.3	8.6
45-64 years	25.4	23.3	28.9	27.4	20.3	18.0
65+ years	45.4	55.4	42.5	50.8	49.7	61.6

Table 7. Life expectancy for men and women, Argentina, 1960, 1970, and 1980.

Years	Both	Men	Women
1960	61.1	59.3	62.2
1970	67.4	63.3	69.5
1980	68.7	65.4	72.1

With regard to the leading causes of death in women, no great differences were observed for any age groups between 1970 and 1983 (Table 8). The leading cause was diseases of the heart, which showed a relative increase in 1983. In second place were malignant neoplasms, which showed a very similar relative frequency in these years. In third place was cerebrovascular disease, with a slight upward trend. Accidents, which in 1970 were the fourth most frequent cause of death, dropped to sixth place in 1983, while maintaining the same percentage. In 1983 atherosclerosis occupied fourth place by frequency of occurrence, and perinatal conditions were in fifth place. The relative increase in atherosclerosis between 1970 and 1983 can be associated with the aging of the population as well as

Table 8. Five leading causes of death in women, Argentina, 1970 and 1983.

	1970			1983		
Causes	No.	%	Rank	No.	%	Rank
All causes	91,429	100.0	—	109,279	100.0	—
Diseases of the heart	21,689	23.7	1	34,365	31.4	1
Malignant neoplasms	14,824	16.2	2	18,088	16.6	2
Cerebrovascular disease	9,388	10.3	3	12,521	11.5	3
Accidents	3,324	3.6	4	3,331	3.6	6
Influenza/pneumonia	4,401	4.8	5	—	—	—
Atherosclerosis	—	—	—	5,776	5.3	4
Perinatal conditions	—	—	—	3,715	3.4	5

with changes in the diagnostic choices of the health services. The eating habits of the country's population contribute to a high percentage of arteriosclerotic and vascular lesions. The fact that perinatal conditions occupied fifth place in 1983 is evidence of the health problems related to reproduction that still afflict women.

We will now analyze the leading causes of death among midlife women (Table 9). Between 1970 and 1983, there was little change in the number of malignant neoplasms, which in this age group were the leading cause of death, or in the number of diseases of the heart, which occupied second place. Cerebrovascular disease was in third place, with a greater relative weight in 1983. Diabetes, in fourth place in both years, was a significant health problem in women of this age group, and its relative weight remained constant. Accidents were the fifth cause of death by frequency of occurrence, with a slight relative decrease in 1983.

The strikingly high relative weight of malignant neoplasms in these women—one out of every three women who die between 50 and 64 years

Table 9. Five leading causes of death in midlife women, Argentina, 1970 and 1983.

	1970			1983		
Causes	No.	%	Rank	No.	%	Rank
All causes	18,541	100.0	—	16,416	100.0	—
Malignant neoplasms	5,526	30.4	1	5,021	30.5	1
Cardiovascular disease	4,218	23.2	2	4,332	26.3	2
Cerebrovascular disease	1,966	10.8	3	2,041	12.4	3
Diabetes	605	3.3	4	530	3.2	4
Accidents	582	3.2	5	449	2.7	5

of age succumbs to cancer—shows the need to intensify control of these afflictions, especially female cancers, whose rates are considerable. In 1980, one of every five women who died of cancer in Argentina had breast cancer.

Although cancer of the cervix was in eighth place among deaths due to cancer in Argentina in 1980, its specific rate showed an increase in 1980, indicating the persistence of the disease. This reemphasizes the need to develop specific programs that will permit early diagnosis and prompt treatment, in order to decrease mortality from female cancers.

Cancers of the colon and stomach are the other cancers of notable frequency, which indicates the need to establish standards for programs of control and early detection.

Until 1980, lung cancer occupied fifth place in frequency of cancer deaths among Argentine women. However, the considerable increase in the number of women who smoke, the amount they smoke, and the persistence of the habit observed over the last two decades lead one to suspect that there will be an increase in mortality from this type of cancer in the coming years.

What do women 65 and over die of in Argentina? Both in 1970 and 1983, the three leading causes were the same: diseases of the heart, malignant neoplasms, and cerebrovascular disease. In 1970, the fourth cause was diabetes and the fifth, influenza and pneumonia. In 1983, atherosclerosis occupied fourth place, and diabetes the fifth by frequency of occurrence. The increase in atherosclerosis in 1983 is probably associated with better means of diagnosis. Diabetes in this group showed a relative decrease, remaining among the five leading causes, which shows its importance as a health problem in midlife and older women.

Special consideration should be given to the problem of mental disorders and external conditions that lead to death among females. Although these problems do not appear among the five leading causes of death, they are clearly of considerable magnitude. Suicide and self-inflicted injuries are the most important, making up 36.5% of all deaths from these causes. In second place are injuries for which it is not known if they were intentional (19.5%), and in third place are mental disorders with 18.7%. Homicide and injuries intentionally inflicted by others make up 17.4%. Alcoholism was reported in 7.4% of these deaths. If alcoholism and mental disorders are considered together, they make up 26.1% of these deaths, occupying second place by frequency of occurrence.

The high frequency of suicides, mental disorders, and alcoholism in female mortality shows that problems of addiction and mental imbalances, if not resolved, lead to death.

But do these conditions affect all age groups in the same way? They do not. It is clear that the group most affected is that of women between 19 and 30 years of age. Midlife women, that is, those from 50 to 64, are the next group in order of importance. It is interesting to observe that in this age group alcoholism and suicide are the mental disorders that most frequently lead to death, reflecting the fundamental crisis characteristic of the midlife woman, with its greater risk of drug and alcohol consumption as a way of trying to resolve the crisis.

Morbidity can only be studied by means of hospital releases by age and cause (Table 10). These data only partly reflect the real situation since only about half of hospital internments are in public hospitals. Thus it is not possible to know about the other half of hospital releases that occur in private or social welfare establishments. In view of the fact that the population that is cared for in public hospitals is the most economically needy, there are biases in these data that make it difficult to extrapolate them to the whole population.

Some conditions that were not detected by mortality data, such as parasitic and infectious diseases, respiratory diseases, and malnutrition, appear prominently among the hospital release data. Although the leading cause of morbidity is digestive conditions, these are usually cured and therefore rarely appear in the mortality data. The same can be said of respiratory diseases, which no longer appear among the leading causes of death as they did in 1970.

Mental disorders are seen with greater frequency among hospital releases than is diabetes. This can be attributed to the fact that mental illness is generally treated in public hospitals and very rarely in private hos-

Table 10. Public hospital releases for women, by cause and age group, Argentina, 1983.

	50–64 years		65+ years	
Diagnosis	%	Rank	%	Rank
Diseases of the digestive tract	22.1	1	14.6	2
Diseases of the circulatory system	17.6	2	30.4	1
Neoplasms	11.6	3	9.0	4
Respiratory diseases	9.1	4	11.0	3
Injuries and poisonings	6.3	5	8.5	5
Infectious and parasitic diseases	5.4	6	5.5	6
Mental disorders	4.4	7	1.9	8
Diabetes	3.0	8	3.0	7
Malnutrition	0.2	9	0.3	9
Other defined causes	20.0	—	16.1	—
All well-defined causes	100.0	—	100.0	—

pitals, while diabetes is treated in both. We have already mentioned the importance of these conditions as a health problem in midlife women and their reflection in mortality. Another frequent, though unreported, pathology is the excessive consumption of drugs and medicines, especially self-prescribed ones, that affects women. This problem appears at adult ages and takes on greater relative weight during midlife and old age.

Based on the morbidity and mortality data analyzed, we can point out the weight of chronic degenerative conditions and mental disorders in women. These conditions can be associated with characteristics of women's lifestyle in this country, namely the double work load within and outside the home, almost exclusive responsibility for care of the home and children, eating habits that favor a very unbalanced diet, little exercise, and a strong tendency to inactivity and obesity. In addition, increasingly demanding situations have arisen from social and economic crises, affecting family stability and fostering the appearance and externalization of life crises that both the population and health providers seek to resolve with the aid of drugs, especially sedatives and antidepressants, which carries the risk of increased mental disorders.

The foregoing leads us to emphasize the need to face these women's health problems from an intersectoral and interdisciplinary point of view, aimed basically at obtaining their active participation not only in the study of the problem, but also in the search for solutions.

Healthier lives can be achieved through increased physical activity, improved diet with the resulting loss of weight, stopping the smoking habit, and periodic checkups for some specific conditions. These are the most important lines of activity to develop in the health and social services with the participation of the women themselves.

Achieving these goals will require that women play an active role and that appropriate health care services be available. It will be necessary to promote the organization and participation of women in caring for their own health and in interacting with health services, which will permit a general mobilization of other population groups to occur, starting with adult, midlife, and elderly women interested in health care.

In order to mobilize women, it is helpful to begin by disseminating information on the relation between health status and their own lifestyles, nutrition, rest, and recreation. An analysis based on this relationship and its health consequences will allow the development of new attitudes and habits for women and their families. At the same time, working with health providers will also be required.

This approach will not be quick or easy, but it seems to be the most appropriate one in keeping with implementation of the primary care strategy to achieve "health for all" by the beginning of the next century.

PATTERNS OF MEDICAL SERVICE USE AMONG MIDLIFE AND OLDER WOMEN IN COSTA RICA

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JUSTIFICATION

The population of Costa Rica, which in 1986 was 2,715,832 inhabitants, is expected to reach 5,250,122 by the year 2025. The country has a relatively young population. One indicator of this is the ratio of men to women. In 1986 the overall ratio of males to females was 102.1 to 100, a statistic that varied between age groups, starting at 104.1 to 100 for those less than one year of age, slowly decreasing to 1:1 for the 40- to 44-year age group, reversing at 45 years of age, and going down to 77.6 men for every 100 women by the age of 80 and above. Women 45 and over make up 7.9% of the total population, 15.9% of the female population, and 51.2% of the population 45 and over.

Projections indicate that by the year 2025, the male to female ratio will have declined to 101 men for every 100 women. It will not be reversed until after 54 years of age, but will go down to 65 men for every 100 women by the age of 80 and above. Thus, by the year 2025, women 45 and older will make up 15.8% of the total population, and 31.7% of the country's female population. These figures justify studies aimed at a better understanding of this particular group so that Costa Rican society can meet their needs adequately.

BACKGROUND

A study done in Costa Rica in 1986, based on data available from the Costa Rican Social Security Fund (Caja Costarricense de Seguridad Social, or CCSS), showed some differences in the causes of medical consultation and hospitalization between men and women 60 and older. The study refers to this age group as a whole. It shows that the pattern observed for the population under 60—in which women seek consultation and become hospitalized more often than men but have shorter hospital stays—changes for persons 60 and above: the men are hospitalized more often than the women and the women's hospital stays are about the same length as the men's. However, women continue to seek consultation more frequently.

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It is recognized that in the age group of young adults, women are hospitalized more than men for obstetrical reasons, and for the same reason their hospital stays are shorter and medical consultations more frequent. However, it is not clear why they continue to make more frequent use of medical consultation after reproductive age.

It was also observed in the aforementioned study that for both sexes and for both hospitalizations and consultations, diseases of the circulatory system were the primary cause, accounting for more than 22% in each instance.

Diseases of the osteomuscular system and connective tissue occupied second place as cause of consultation for both sexes (13.8% and 13.2%), while in second place as cause of hospitalization was diseases of the digestive tract for men (10.9%) and diseases of the respiratory tract for women (12.0%). In third place were diseases of the respiratory tract as cause of consultation and hospitalization in men (10.3% and 10.4%), while for women third place was occupied by diseases of the endocrine glands for medical consultation (10.0%) and diseases of the digestive tract for hospitalization (10.3%).

These differences justify the proposal for more detailed studies, since this is an age group (60 and above) whose characteristics are little known in Costa Rica.

The present study, using the same data obtained in the foregoing study, analyzes the information for smaller age groups, looking only at females, and aggregating the 45 to 59-year age group.

OBJECTIVES

The general objective of the study presented in this paper is to examine in more detail the patterns of use and the morbidity reported in the CCSS medical services among women 45 and older, and to describe the differences and similarities among three age groups:

- midlife women (from 45 to 59 years),
- older women (from 60 to 74 years),
- elderly women (75 and above).

These differences and similarities were investigated in three areas:

- the relative proportions of these groups as patients in outpatient consultation and hospitalized in CCSS services;
- indirect coverage indicators of the consultation and hospitalization services of the CCSS;
- the most frequent causes of consultation and hospitalization.

SOURCES OF INFORMATION

The number of consultations by age, sex, and cause was estimated based on the 10,961 health service users who stated they were 45 years of age or older in the 1985 national survey on causes of medical consultation. The survey is a collaborative work carried out every two years by two sections of the Technical Office of Health Services of the CCSS. In this survey data was gathered from 40,433 health service users chosen at random and proportioned among all the clinics and hospitals of the CCSS, where about six and a half million consultations a year (2.3 per inhabitant) are made.

The data on hospitalization services were obtained from statistical records of hospital releases, which are collected, coded, reviewed, and tabulated regularly as part of the ongoing institutional statistics of the CCSS medical services. In 1986 there were a total of 298,632 releases, of which 20.8% were persons 45 years of age or older.

The medical services of the CCSS cover 80% of the medical consultations in the public sector, and they also cover 96% of the hospitalizations in the whole country; more than 90% of the births and around 40% of the deaths take place there. This represents a ratio of 231 consultations and 12 hospital releases per year for every 100 inhabitants. This high usage occurs because it is not necessary to make the payments typically required in order to receive care in these services—theoretically, the whole population has access to them. Figures for the general population were taken from the "Population Estimates and Projections, 1950-2025," of the Ministry of National Planning and Economic Policy, Office of Statistics and Censuses, and the Latin American Demography Center, January 1988.

RESULTS

Relative Importance of the Three Age Groups in the Medical Services

As shown in Table 1, in 1986 Costa Rican women, who make up 49% of the total population of the country, used 64.2% of the medical consultations and accounted for 67% of the hospitalizations in the clinics and hospitals of the Costa Rican Social Security Fund. They also accounted for 52.8% of the hospital stays, but their average length of stay was 5.3 days as compared to 9.6 days for men.

As would be expected, the figures are highest in the group under 45 years of age, where the discrepancies between the two sexes are explained by women's increased needs for medical care during the fertile years. Almost 43% of the female hospitalizations are for birth or miscarriage.

However, Table 1 also shows that this pattern persisted in the 45 to 59 age group (midlife), since these women continued to use more consultations and have more hospitalizations. Their average stay, though it increased to 10.7 days, was still 60% lower than that of men, at 16.1 days.

Table 1. Medical consultations, hospital releases, and hospital stays (absolute and relative figures), by age and sex, CCSS medical services, Costa Rica, 1986.

Age and sex	Medical consults		Hospital releases		Hospital stays		
	Number	%	Number	%	Number	%	Avg. stay (days)
National total	6,049,374	100.0	298,632	100.0	2,009,465	100.0	6.7
Male	2,167,044	35.8	98,688	33.0	947,903	47.2	9.6
Female	3,882,330	64.2	199,944	67.0	1,061,562	52.8	5.3
0 to 44 years	4,210,364	69.6	236,517	79.2	1,113,202	55.4	4.7
Male	1,562,615	25.8	67,964	22.8	462,155	23.0	6.8
Female	2,647,749	43.8	168,553	56.4	651,047	32.4	3.9
45 to 59 years	919,505	15.2	24,786	8.3	322,747	16.1	13.0
Male	255,627	4.2	10,590	3.5	170,339	8.5	16.1
Female	663,878	11.0	14,196	4.8	152,408	7.6	10.7
60 to 74 years	683,579	11.3	22,995	7.7	360,269	18.0	15.7
Male	248,758	4.1	12,598	4.2	200,220	10.0	15.8
Female	434,821	7.2	10,397	3.5	160,049	8.0	15.4
75 to 99 years	235,926	3.9	14,334	4.8	213,247	10.6	14.9
Male	100,044	1.7	7,536	2.5	115,189	5.7	15.3
Female	135,882	2.2	6,798	2.3	98,058	4.9	14.4

After 59 years of age, female consultations continue to be more frequent while hospitalizations are less frequent than those of men, and the difference in average length of stay practically disappears, although it continues to be a little lower for women.

In summary, in 1986 women over 45 represented 7.9% of the country's total population, but they used 20.4% of the consultations given at the CCSS and made up 10.5% of the total hospital releases; men of the same age, who represented 7.5% of the population, used 10% of the consultations and made up 10.3% of the hospital releases. This implies that after 44 years of age the woman's pattern of hospitalization becomes more like that of the man, but she continues to have more frequent consultations, and both sexes in this age group use medical services more often than the rest of the population.

The main differences among the three groups of women compared here are in the average length of hospital stay, which was 3.9 days for those under 45, rose to 10.7 days for the 45 to 59 age group (midlife), continued to rise for the older age group (15.4 days), and decreased slightly for those 75 and above (14.4 days). However, women's average stay was always shorter than that of men in the same age group (Table 1).

Indirect Coverage Indicators

Although we do not currently have the specific data needed to calculate the classic coverage percentages, good information can be obtained by relating the figures for medical consultations and hospital releases for women 45 and above with the respective population. Table 2 presents such data by five-year age groups; this allows us to see that the rate of consultations per year for each woman is 5.8 for the whole group, and that it varies from 5.2 for the 45 to 59 age group (midlife) up to 7.0 for those 75 and above. This is in contrast to the national indicator of 2.3 consultations a year per inhabitant and is greater than the 4.9 consultations for the whole population of 60 and above.

The tendency is similar for hospitalizations. The rate is 1.1 releases for every 10 women in the midlife group, and it goes up to 3.5 per 10 women in the elderly (75 and above) age group.

If we look at five-year age groups, some discrepancies can be seen in these same indicators, since as the proportions of population, consultations, and hospital releases in an age group tend to go down with increasing age, the relative participation in the consultations becomes greater in the population of 60 and above. The same thing occurs with hospital releases beginning at 65 years of age. As a result, it can be observed in Table

Table 2. Population, medical consultations, hospital releases, and average lengths of stay of women 45 and over, by age group, CCSS, Costa Rica, 1986.

		Medical consults		Hospital releases		
Age in years	% of total population	% of total	Per woman	% of total	Per 10 women	Avg. stay (days)
45 to 59	59.5	53.8	5.2	45.2	1.1	10.7
45-49	23.0	20.9	5.3	18.1	1.2	8.3
50-54	19.9	17.3	5.0	14.4	1.1	11.5
55-59	16 6	15.6	5.4	12.7	1.1	13.4
60 to 74	31.3	35.2	6.5	33.1	1.6	15.4
60-64	13.3	14.2	6.2	11.3	1.3	15.3
65-69	10.4	11.0	6.1	10.7	1.5	12.3
70-74	7.6	10.0	7.6	11.3	2.2	18.0
75 and over	9.2	11.0	7.0	21.7	3.5	14.4
75-79	5.0	6.9	7.9	10.1	2.9	13.3
80-99	4.1	4.1	5.6	11.5	4.1	15.5
Total no.	213,275	1,234,581	—	31,391	—	—
Overall rates	—	—	5.8	—	1.5	13.1

2 that the ratio of consultations per inhabitant is very high in the 70 to 74 age group and in the 75 to 79 age group (with 7.6 and 7.9 consultations per year per woman, respectively). The lowest figure is for women 50 to 54 years of age; actually, the figures for women between 45 and 59 years of age are lower than those for all women 45 and above, and more so when they are considered as a single group. The lowest average length of hospital stay is for women from 45 to 59, and the highest is in the 70 to 74 age group (8.3 and 18.0 days, respectively).

Most Frequent Causes of Consultation and Hospitalization

The patterns of medical service use shown by Costa Rican women 45 and over, as evidenced by the foregoing data, are undoubtedly a result of factors that must be determined so that we can understand and influence them. Although it is not within the scope of this work to determine the associated factors, but rather to describe these patterns or trends, the source of the data used allows us to describe one of the factors that may explain a good part of the medical services usage patterns. This factor is the causes of consultation and hospitalization.

In order to simplify the overall analysis, Table 3 presents the consulta-

Table 3. Medical consultations and hospital releases of women 45 and over, by cause and age, CCSS, 1986.

	Consultations						Releases					
	45-59		60-74		75-99		45-59		60-74		75-99	
Cause	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Healthy controls, with no pathologies	5.0	9	2.2	11	0.7	15	2.2	12	1.9	13	2.3	12
Infectious and parasitic diseases	1.9	11	1.6	12	1.6	12	2.5	11	3.0	11	4.3	9
Neoplasms	1.3	12	1.1	13	0.8	14	13.1	2	9.2	5	6.8	7
Endocrine and metabolic nutritional diseases	9.3	4	11.6	3	9.6	3	7.5	5	10.9	4	7.7	6
Diseases of the blood and hematopoietic organs	0.9	14	1.0	14	1.0	13	0.6	16	1.0	14	1.1	13
Mental disorders	7.3	5	5.7	8	3.7	9	5.1	8	3.9	9	2.6	11
Diseases of the nervous system	5.5	8	6.9	7	9.0	4	4.4	10	8.1	6	7.9	5
Diseases of the circulatory system	18.9	1	24.6	1	29.2	1	12.0	3	20.2	1	25.1	1
Diseases of the respiratory tract	9.6	3	9.1	4	8.5	5	6.0	6	11.0	3	13.7	2
Diseases of the digestive tract	7.3	5	7.2	6	8.2	6	11.0	4	11.3	2	8.6	4
Diseases of the genitourinary tract	7.0	7	4.1	9	3.5	10	19.8	1	6.7	7	4.4	8
Obstetrical conditions	0.0005	16	—		—		2.1	13	—		—	
Diseases of the skin	7.2	6	7.3	5	7.6	7	2.0	14	2.6	12	3.0	10
Diseases of the osteomuscular system	13.2	2	13.0	2	10.1	2	5.8	7	3.8	10	2.3	12
Congenital anomalies	0.0009	15	0.0004	15	—		0.3	17	0.1	16	—	
Injuries and poisonings	1.2	13	1.1	13	1.9	11	4.8	9	5.5	8	9.2	3
Signs, symptoms, and ill-defined conditions	4.2	10	3.4	10	4.4	8	0.8	15	0.8	15	0.9	14
Total number	664,204		434,573		135,804		14,180		10,477		6,776	

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tions and hospital releases of the three age groups under study by headings in the *International Classification of Diseases* (9th revision). In this way it is easy to see that the leading cause of consultation for all women over 44 is diseases of the circulatory system. It is also shown to be the leading cause of hospitalization after 60, and its relative weight increases with age. The leading cause of hospitalization for women 45 to 59 are diseases of the genitourinary tract, which occupy seventh and eighth places for the two older age groups. Diseases of the osteomuscular system are the second most common cause of consultation for all three age groups, but their relative weight goes down with increasing age. On the other hand, the second most common cause of hospitalization varies: Neoplasms, which occupy second place in the youngest age group, are in fifth and seventh place as the cause of hospitalization as age increases. Diseases of the digestive tract, which are the second most frequent cause of hospitalization in the 60 to 74 group, occupy fourth place in the other two age groups; and diseases of the respiratory tract, which occupy the second place among the oldest elderly (75 and above) appear in sixth place in the 45 to 59 age group and in third place in the 60 to 74 age group. It is important to point out that injuries and poisonings, which occupy the ninth and eighth places as causes of hospitalization for persons 45 to 59 and 60 to 74 years of age, respectively, move up to third place at the oldest ages.

In order to explore in greater detail the differences observed in the causes of medical service use, the most frequent causes are listed in Tables 4 and 5. The causes selected were those that explained at least 1% of the consultations or releases in at least one of the three groups of women.

The causes presented in Table 4 together explain more than 70% of the medical consultations in each of the three age groups. Those in Table 5 cover slightly less than 60% of the hospital releases in the same groups of women.

In Table 4, which shows causes for medical consultations, we can see that hypertensive disease is the leading cause in the three groups, with a relative weight that goes from 14.6% in middle age to around 19.0% at the more advanced ages. The second most common cause of consultation in midlife is neurotic personality disorders (5.8%), which are in fifth place for the older age group and in tenth among the elderly. Diabetes mellitus, which occupies third place in midlife (5.7%), is the second most frequent cause of consultation in the other two groups, accounting for 8.5% and 7.3% of consultations, respectively.

Other frequent causes of consultation in the three groups are the arthropathies, aggravated skin conditions, and gastritis and duodenitis. Of note are ischemic heart disease, which occupies fifth place in the oldest

Table 4. Medical consultations by women 45 and over, by age and most frequent causes, CCSS, 1986.

Cause (ICD, 9th Rev.)	Age in years					
	45–59		60–74		75–99	
	%	Rank	%	Rank	%	Rank
Hypertensive disease (401-405)	14.6	1	19.0	1	18.7	1
Neurotic personality disorders (300-301)	5.8	2	4.0	5	2.4	10
Diabetes mellitus (250)	5.7	3	8.5	2	7.3	2
Arthropathies and similar conditions (710-719)	5.2	4	5.9	3	4.9	4
Aggravated skin conditions (690-709)	5.0	5	5.0	4	5.2	3
Ischemic heart disease (410-414)	0.8	16	1.8	12	4.8	5
Dorsopathies (720-740)	4.1	6	3.1	7	1.9	14
Gastritis and duodenitis (535)	3.6	7	3.4	6	3.4	6
Other diseases of the digestive tract (577-579)	2.6	8	2.6	8	3.0	7
Skin infections (680-687)	2.2	9	2.3	10	2.3	11
Rheumatism, excluding the back (725-729)	2.2	9	2.5	9	2.1	13
Chronic pharyngitis, rhinopharyngitis, and sinusitis (472-473)	2.2	9	1.7	13	0.8	
Varicose veins of the leg (454)	2.0	10	2.2	11	1.8	15
Bronchitis—all forms (466, 490-491)	1.3	16	2.5	9	3.0	7
Cataracts (366)	0.2		1.1	18	2.7	9
Other eye and related disorders (367-371, 373-379)	1.6	13	2.3	10	2.9	8
Asthma (493)	1.8	11	1.6	14	1.3	17
Osteopathies, chondropathies, and deformities of the osteomuscular system (730-739)	1.8	11	1.4	16	1.2	18
Thyroid diseases (240-246)	1.8	11	1.2	17	1.1	19
Cystitis (595)	1.7	12	1.1	18	1.5	16
Diseases of the nervous system (320-359)	1.5	14	1.5	15	1.2	18
Routine gynecological examination (V72.3)	1.8	11	0.9		0.1	
Circulatory and pulmonary disease, and other diseases of the heart (415-429)	0.3		0.6		2.2	12
Vaginal cytology (V76.2)	1.7	12	0.8		0.1	
Aggravated diseases of the uterus, vagina, and vulva (614-616)	1.4	15	0.6		0.2	
All other causes	27.1		22.4		23.9	
Total no. of consultations	663,878		434,821		135,882	

Table 5. Hospital releases of women 45 and over, by age and most frequent causes, CCSS, 1986.

Cause (ICD, 9th Rev.)	Age in years					
	45–59		60–74		75–99	
	%	Rank	%	Rank	%	Rank
Diabetes mellitus (250)	5.3	1	11.0	1	6.5	1
Menstrual disorders (626)	5.1	2	0.1		—	
Ischemic heart disease (414)	0.9	15	4.0	3	6.3	2
Disorders of the menopause and post-menopause (627)	4.1	3	1.0	15	0.2	
Cataracts (366)	1.0	14	4.5	2	4.5	5
Varicose veins of the leg (454)	4.0	4	2.7	6	2.1	9
Fracture of the femur (820)	0.1		1.3	12	4.8	4
Cholelithiases (574)	3.4	5	3.3	4	1.5	12
Chronic obstructive pulmonary disease (496)	1.2	12	3.2	5	6.0	3
Asthma (493)	2.8	6	1.8	8	0.8	
Cardiac insufficiency (428)	0.5		1.6	9	3.1	6
Uterine leiomyoma (218)	2.7	7	0.1		0.1	
Bronchopneumonia (485)	0.2		0.7		2.3	8
Genital prolapse (618)	2.7	7	2.3	7	1.2	14
Essential hypertension (401)	1.9	8	2.6	6	1.6	11
Schizophrenic psychosis (295)	1.9	8	0.9		0.1	
Ill-defined intestinal infections (009)	1.1	13	1.4	11	2.5	7
Uncomplicated abdominal hernia (553)	1.8	9	1.3	12	0.6	
Malignant neoplasm of the cervix (180)	1.8	9	1.5	10	0.8	
Other disorders of the uterus (621)	1.4	10	0.1		0.03	
Hypertensive heart disease (402)	0.4		1.4	11	1.7	10
Affective psychoses (296)	1.3	11	1.4	11	0.5	
Cellulitis and abscesses (681-682)	1.0	14	1.4	11	1.1	15
Acute but ill-defined cerebrovascular disease (436)	0.3		1.1	14	1.6	11
Nonspecific dorsopathies (724)	1.3	11	0.6		0.4	
Genitourinary neoplasm of uncertain origin (236)	1.2	12	0.1		0.4	
Nontoxic nodular goiter (241)	1.2	12	0.6		0.2	
Malignant neoplasm of the breast (174)	1.1	13	1.1	14	1.3	13
Other disorders of the urethra and urinary tract (599)	1.1	13	1.2	13	1.1	15
Gastritis and duodenitis (535)	0.7		1.0	15	1.2	14
Malignant breast dysplasia (610)	1.0	14	0.1			
Stomach cancer (151)	0.4		0.9		1.1	15
All others	45.1		43.7		44.8	
Total no. of releases	14,196		10,397		6,798	

and twelfth in the 60 to 74 age group, and back problems, which occupy sixth and seventh places before 75 years of age, and then drop to fourteenth place. The relative importance of bronchitis and cataracts increases with age. The opposite trend is observed with respect to skin infections and varicose veins of the leg.

In Table 5, it is notable that diabetes mellitus occupies first place as cause of hospitalization for all age groups and that its frequency is greatest in the 60 to 74 group, accounting for 11% of the total releases in that group. For midlife women (45-59), menstrual disorders are the second most common cause of hospitalization, and disorders related to menopause are the third—causes that are not important in the other two age groups. The second cause of hospitalization in women 60 to 74 is cataracts, and the third is ischemic heart disease, which in turn is second in the 75 and above group. Chronic obstructive pulmonary disease occupies third place among the most elderly as a cause of hospitalization.

It should be noted from Table 5 that the relative importance of varicose veins of the leg as a cause of hospitalization declines with age, as it does for this condition as a cause of consultation. Meanwhile, the relative frequencies of fracture of the femur, intestinal infection of unknown cause, cardiac insufficiency, and bronchopneumonia increase with age.

Consistent with the causes of hospitalization, 47.2% of the hospital releases in the 45-year age group are after surgical intervention: 5.5% of these surgeries are hysterectomies, 10.5% are other operations on the uterus and its related structures, and 3.2% are operations on the bile ducts. Other operations of some frequency are breast surgery (2.2%), surgery on the peripheral blood vessels (2.2%), and surgical repair of abdominal hernia (2%). There is less surgery in the older age group (60 to 74 years); it is performed in 29.9% of hospital releases, most frequently for operations on the lens and vitreous humor (4.2%), bile ducts (3.0%), surgical repair of abdominal hernia (1.6%), and hysterectomy (1.5%). Only 15.3% of the women 75 and over released from the hospital have had surgery, the most frequent operations being those on the lens and vitreous humor (4.1%), followed by reduction of fracture or of dislocation with hip fracture (3.1%), and operations on the bile ducts (1.2%).

In summary, surgical interventions are frequent in women 45 and over, but their relative importance declines with age.

DISCUSSION

This study clearly established that women 45 and over in Costa Rica, representing 7.9% of the country's total population, account for 20.4% of the medical consultations and represent 10.5% of the hospital releases in the CCSS. According to a 1984 population study, 86.8% of women 60 and over have a right to CCSS services, and the state pays for the rest to receive CCSS care as well. Furthermore, in the same study it was observed that 94.5% of the women over 60 stated they made frequent use of these services, the percentage increasing to 95.5% for the 65 to 74 age group. Thus it can be affirmed that the Social Security data faithfully reflect the health status of this group, and there is no reason to suppose that the situation is any different with respect to women between 45 and 59 years of age.

The patterns of medical service use shown by women 45 and over in Costa Rica are no different from those found in other countries in which this group has the same or greater relative importance within the general population. After reproductive age, women continue to seek medical consultation more than men, and they continue to have shorter hospital stays. The number of consultations per inhabitant is very high in this group, going from 5.0 per year among those 50 to 54 years of age, to 7.9 per year among those 75 to 79 years of age. Hospitalizations are also frequent.

These patterns are explained by the most frequent causes of care: diabetes, hypertensive disease, ischemic heart disease, arthropathies, and back problems. The differences among the three groups are greater between the 45-59 age group and the other two, since the former still have health problems related to reproduction and to physiologic changes accompanying older age in women.

However, diabetes mellitus and cardiovascular diseases, diseases that are closely associated with customs and lifestyle, occupy first place as causes of hospitalization and medical consultations, respectively, in all three groups, which is compatible with the findings of other studies.

It cannot be said that Costa Rica thus far has the political will to plan preventive measures to reduce the prevalence of these conditions. The emphasis is still on birth and early childhood, the same as in any other Third World country.

The results of this study show clearly that midlife and older women seek medical attention and that the CCSS commits a large portion of its resources to their care. But it would be appropriate here to reflect on whether the resources are directed correctly, so that these women receive care in accordance with their most prevalent conditions. This pattern of use might vary if the form of care were to change. In health, as in any other field that is influenced by society, supply can be determined by demand, but the characteristics of demand are often largely associated with the type of service supplied. Thus there is no doubt that the group studied is large and important enough to merit attention to the problems reflected in their patterns of medical service use.

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THE HEALTH STATUS OF THE PUERTO RICAN ELDERLY: PUBLIC HEALTH POLICY IMPLICATIONS

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Health is a central concern of the aged since it cuts across all social, occupational, and economic lines and affects their situation in the spheres of family life, employment, recreation, and community involvement. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition.

Measurement of health status can serve, among other purposes, to clarify the need for additional professional services such as rehabilitation, outpatient clinics, nursing homes, medical and other health personnel, and medical insurance coverage. The parameters generally used for measuring a population's health are life expectancy (at birth and at later ages), mortality rates, and morbidity rates.

Patterns of illness and disease distribution are culture-bound and influenced by social and demographic variables such as sex, age, race, climate, population distribution (e.g., urban or rural), and economic development. In developed countries the disease picture is different from that in developing countries, having changed substantially in the past decades. Whereas acute conditions predominated at the turn of the century in the now developed countries, at present, chronic conditions are the most prevalent health problem. This change is a direct consequence of the growth of the older population segments.

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Health of the aged can be defined either in terms of the presence or absence of disease or, alternatively, in terms of how well the older person is functioning. The World Health Organization (WHO) has stated that health in the elderly is best measured in terms of function and degree of fitness, rather than in extent of pathology, and that these measures may be useful in determining the amount of services the aged will require from the community.

A WHO report in 1974 on the planning and organization of geriatric services stated that the medical profession had accepted that morbidity should be measured not only in terms of the extent of the pathological process but also in terms of impairment of function in the person by a pathological condition. Impairment was defined as a physiological or psychological abnormality that does not interfere with the normal life activities of the individual, and disability as a condition which results in partial or total limitation of the normal activities of the individual.

Studies in Europe and the United States have shown that the majority of persons aged 65 years and over do not have good health and that this situation worsens progressively with increasing age.

A study in Europe found that multiple morbidity is characteristic of the elderly: three or more chronic diseases are found in more than 50% of people aged 60 years and over. In the United States, among the 90% of the elderly who reported a health problem, 90% of them reported having multiple problems, with the average being 4.1 per person. Virtually everyone who had a current or existing problem reported at least one significant chronic problem. One out of five elderly have at least a mild degree of disability. Over half of the oldest old have no physical disability, but the probability of becoming disabled increases with age. Cross-sectional data have shown that the likelihood of having a chronic illness also increases with age. More than four out of five persons 65 and over have at least one chronic condition, and multiple conditions are commonplace. In the United States in 1982, the leading chronic conditions causing limitation of activity among the elderly were arthritis, hypertensive disease, hearing impairment, and heart conditions.

The three principal health problems most often identified by the elderly were heart disease, high blood pressure, and diabetes, or some combination of these. The types of conditions experienced by older people vary with sex and race. Older men are more likely than women to experience acute illnesses that are life threatening, while older women are more likely to have chronic illnesses that cause physical limitation. Most studies have found the general level of health of women to be worse than that of men. In the United States, the health situation of elderly blacks is generally poorer than that of elderly whites. Hypertension was more prevalent among blacks 65 to 74 years old (45%) than among whites (33%). The factor of social class influences health status in the United States; the elderly poor have the worst health of any group.

A study in Europe found somewhat higher rates of signs and symptoms of disease in females than in males, and a slight increase with increasing age in the prevalence of symptoms in age cohorts. The leading symptoms were aching or pain in the joints, back trouble, tiredness, feeling of faintness, and nervous tension or nervousness. The rates of these symptoms were higher for women than men, but did not increase significantly by age cohort. Women reported tiredness or a feeling of faintness more often than men and a clear increase in this symptom's prevalence was observed in the older age groups. Women reported higher rates of nervous tension and nervousness than men, but prevalence of this symptom decreased in the older age groups. Symptoms whose prevalence increased from the youngest to the oldest age groups were impaired memory and constipation. The percentage of persons reporting problems in hearing what others said increased rapidly in increasing age-group cohorts. Slightly higher prevalence rates were reported by men than women. In turn, women were affected more often than men by vision problems, and this condition was more frequent in the oldest age group.

In the United States, older people have been found to have proportionally fewer mental illness problems than do other age groups. The primary mental health problems of old age result from cognitive impairment. Mild cognitive impairment is found in about 14% of elderly males and females, and severe impairment in 5.6% of elderly men and 3% of elderly women. Alzheimer's disease is the leading cause of cognitive impairment.

Inferences about the health of the Puerto Rican elderly were obtained by reviewing the leading causes of death for 1982, which were found to be, in rank order, heart disease, cancer, cerebrovascular illness, diabetes, and arteriosclerosis. The leading chronic conditions in the same year were arthritis, rheumatism or joint pain, hypertension, heart disease, diabetes, endocrine disorders due to nutrition or metabolism, and vision impairment. This list did not differ between the sexes.

A study of an institutionalized elderly population in the San Juan Metropolitan Area of Puerto Rico found that the most frequent health problems, in order of prevalence, were arthritis, high blood pressure, constipation, dizziness, difficulty in sleeping, and dry skin. Lastly, an exploratory study in the Municipality of Cabo Rojo, Puerto Rico, found the most frequent health problems to be impaired vision, arthritis, high blood pressure, dizziness, and hearing difficulty.

METHODS

A study was performed to determine the health status of an island-wide sample of noninstitutionalized elderly respondents. The existence of differences between subgroups of this population would reveal the need to develop intervention strategies at either the "macro" (societal) public health policy level or the "micro" (subsystem) level.

This study is based on part of a 31-page questionnaire (173 questions) concerning the social-demographic status of the Puerto Rican elderly. The questions pertaining to health status consisted of nine items on background information and ten questions relating to health problems. Respondents were asked to indicate the timing of health problems on a scale of 0 to 2: a 0 meant that the respondent had never had the condition, 1 signified that the respondent had suffered from the condition in the past, and 2 meant that the respondent continued to suffer from the condition at the time of the interview.

A pretest of the questionnaire was carried out in Cabo Rojo, Puerto Rico, in December 1982. At that time, a random sample of 207 elderly were interviewed. This group came from the first three trimester population samples of the 1982 Master Sample Survey of the Department of Health of Puerto Rico. The basic purpose of this survey is to obtain information about the quantity and distribution of health problems, the incapacity they cause, and the type of health services they necessitate. The Master Sample Survey is carried out four times in a year and includes a total of approximately 3,400 households (850 per trimester).

Of the 741 senior citizens who were included in the list provided by the Department of Health, 466 were interviewed. The remainder of the interviews were not carried out for the following reasons: the respondent was deceased (105 cases); the respondent had relocated and a forwarding address was not available, the address was never located, or the respondent was not at home when the interviewer visited (111 cases); the respondent was sick in the hospital or was at home but unavailable due to illness (42 cases); the respondent was eliminated from the sample because he or she was not of Puerto Rican origin, the study being limited to that ethnic group (42 cases). Structured interviews were carried out from September 1983 to September 1985. Kendall's Tau B and C tests and Cramer's V test were used to test for significance. Kendall's is a nonparametric statistical test that measures the relationship between two variables when the data are in the form of ranks. Cramer's V test of significance shows whether a systematic relationship exists between two nominal variables.

RESULTS

The sample of 466 respondents was about equally divided between the sexes and almost equally divided between rural and urban areas of the island. The municipalities most represented were San Juan (15%) and Ponce (5%). The great majority of respondents were born in Puerto Rico (97%). The mean age of the population was 73.5 years. The majority of respondents were legally married (54%). Elementary level education predominated (50.6%). For monthly income, the mean was $355. Religious affiliation was predominately Catholic (71%). And lastly, the most prevalent occupation category was blue collar (30%) (Table 1).

The health problems presently affecting respondents, in order of im-

Table 1. Sociodemographic characteristics of respondents in percentage, Puerto Rico, 1982.

Characteristics of population (n = 466)	Percentage
Sex	
Male	50.4
Female	49.6
Area of residence	
Urban	47.9
Rural	52.1
Municipality[a]	
Ponce	5.4
San Juan	14.8
Other	79.8
Birthplace	
Puerto Rico	97.0
United States	1.1
Other	1.9
Age[b]	
64–69	33.3
70–79	48.8
80+	17.9
Marital status	
Legally married	54.3
Consensual union	1.9
Widowed	32.0
Divorced	5.6
Separated	1.3
Never married	4.9

Table 1. (Continued)

Characteristics of population (n = 466)	Percentage
Education[c]	
None	20.5
Elementary	50.6
Intermediate	14.7
High school or more	14.2
Monthly income (US$)[d]	
32-200	35.0
201-350	24.7
351-550	22.1
551+	18.2
Present religion	
Catholic	71.0
Pentecostal	7.9
Baptist	1.1
Evangelical	7.7
Jehova's Witness	2.4
Other	5.4
None	4.5
Occupation	
White collar	14.4
Blue collar	29.8
Agricultural	19.7
Services (household)	5.2
Never worked[e]	30.9

[a] With greater than 5% representation.
[b] Mean age, 73.5 years; median, 72.0.
[c] Mean, 4.7 years of schooling.
[d] Mean monthly income, $355; median, $253.
[e] Homemaker or was never employed.

portance, were arthritis, rheumatism, or joint pain (66%); vision problems (50.6%); and high blood pressure (41%) (Table 2).

A number of independent variables were found to be significantly related to certain conditions. An association was found between oral health problems and zone of residence, with 64% of respondents from the urban zone reporting having suffered from this problem, as compared with 57% of their rural counterparts (Table 3).

A close relationship was found between heart disease and age (Table 4). The proportion of respondents suffering from this condition at the time of the interview increased sharply after 70 years of age (32%) in comparison with that in other age groups (23%).

Table 2. Health problems of survey respondents, Puerto Rico, 1982.

Problem in population (n = 466)	Percentage
Vision problem	
Never	43.9
Only in past	5.6
At present	50.6
Hearing problems	
Never	74.7
Only in past	6.4
At present	18.9
Arthritis, rheumatism, or joint pain	
Never	30.0
Only in past	3.9
At present	66.1
Diabetes	
Never	78.5
Only in past	.9
At present	20.6
Heart disease	
Never	69.5
Only in past	1.5
At present	28.9
High blood pressure	
Never	53.6
Only in past	5.4
At present	41.0
Dizziness	
Never	66.9
Only in past	8.0
At present	25.2
Skin conditions (rash, inflammation, itching, etc.)	
Never	81.5
Only in past	4.1
At present	14.4
Mental health problems	
Never	92.9
Only in past	1.9
At present	5.2
Oral health problems	
Never	60.3
Only in past	24.2
At present	15.5

Table 3. Percentage of respondents with oral health problems, by area of residence, Puerto Rico, 1982.

	Area	
Oral health problems in population (n = 466)	Urban (n = 223)	Rural (n = 243)
Never[1]	64.1	56.8
Only in past	20.2	28.0
At present	15.7	15.3

[1] Cramer's V 0.15, significance 0.01.

Table 4. Percentage of respondents with heart disease, by age cohort, Puerto Rico, 1982.

	Age		
Heart disease in population	64–69 years (n = 154)	70–79 years (n = 226)	80+ years (n = 83)
Never[1]	75.3	66.8	65.1
Only in past	1.9	.9	2.4
At present	22.7	32.3	32.5

[1] Tau B 0.08, significance 0.03; Tau C 0.08, significance 0.03.

An association exists between income and health problems of respondents (Table 5). Persons from the highest income category suffered the least from a current vision problem (40%) as compared to those in the lowest income group (57%). This pattern persisted for arthritis, rheumatism, or joint pain (highest income group, 57%, and lowest income group, 72%) and for oral health problems.

Occupation also seemed to have a bearing on health conditions (Table 6). Household service workers (79%) and the never-employed (77%) suffered the most at the time of the interview from arthritis. Household service workers also suffered the most from current heart disease (42%) and high blood pressure (63%).

CONCLUSIONS

The most prevalent health problems in this population (arthritis, hypertension) are similar to those found in the elderly in the United States.

Table 5. Percentage of respondents with health problems, by income category, Puerto Rico, 1982.

	Income in US dollars ($)			
Condition in population (n = 440)	$32-200 (n = 163)	$201-350 (n = 115)	$351-550 (n = 102)	$551+ (n = 60)
Vision problem[a]				
Never	36.8	47.0	46.1	50.0
Only in past	6.1	4.3	3.9	10.0
At present	57.1	48.7	50.0	40.0
Arthritis, rheumatism, or joint pain[b]				
Never	23.9	28.7	33.0	38.3
Only in past	3.7	4.3	3.9	5.0
At present	72.4	66.9	63.1	56.6
Oral health problem[c]				
Never	52.8	59.1	65.0	66.7
Only in past	34.4	21.7	16.5	21.7
At present	12.9	19.1	18.4	7.4

[a] Tau B 0.10, significance 0.00; Tau C 0.09, significance 0.00.
[b] Tau B 0.09, significance 0.01; Tau C 0.08, significance 0.01.
[c] Tau B 0.07, significance 0.04; Tau C 0.06, significance 0.04.

Table 6. Percentage of respondents with health problems, by occupational category, Puerto Rico, 1982.

	Occupation				
Condition in population (n = 457)	White collar (n = 66)	Blue collar (n = 136)	Agriculture (n = 90)	Services (n = 24)	Never worked (n = 141)
Arthritis, rheumatism, joint pain[a]					
Never	28.8	34.6	36.7	20.8	21.3
Only in past	3.0	5.1	5.6	—	2.1
At present	68.2	60.2	57.7	79.2	76.6
Heart disease[b]					
Never	69.7	71.3	71.1	58.3	68.8
Only in past	1.5	1.5	1.1	—	1.4
At present	28.8	27.2	27.8	41.7	29.8
High blood pressure[c]					
Never	54.5	66.2	55.6	33.3	41.8
Only in past	10.6	2.9	4.4	4.2	6.4
At present	34.8	30.9	40.0	62.5	41.7

[a] Cramer's V 0.13, significance 0.02.
[b] Cramer's V 0.13, significance 0.02.
[c] Cramer's V 0.17, significance 0.02.

The finding that the prevalence of cardiac conditions increases with age is important for public health purposes since it points to the need to develop and implement preventive medicine strategies, particularly in the areas of health education and nutrition.

The oral health problems were significantly more frequent in the rural population of the island. This could reflect socioeconomic differences between urban and rural populations, with urbanites being more economically advantaged. Also, health services are more concentrated in the San Juan metropolitan area. This concentration is at the expense of the rest of the island, and rural dwellers are significantly socioeconomically disadvantaged. Public health policy should be oriented toward decentralizing health services and strengthening health education and nutrition services to this population. The findings about oral illness raise questions relative to the variance of water quality and nutritional practices by zone.

Socioeconomic status was found to significantly influence prevalence of health problems. This finding is similar to those of studies in the United States, Mexico, Argentina, and other countries. Also, marriage was significantly correlated with lower rates for a number of health problems, a finding similar to those of other research in Puerto Rico and the United States.

An interesting finding was that household service workers suffered significantly more from certain conditions than did people in other occupation categories. This finding requires further investigation by occupational health experts.

The study did not find a relationship between educational level and health status, but this may be due to the fact that the population was generally homogeneous with respect to educational level, the large majority having an elementary education or less.

The study's findings reaffirm the need to prepare for old age by intervening with population groups throughout the life cycle in order to optimize health status. Quality of life must be stressed, not only longevity, in order to maintain human dignity among all the population groups in the society.

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MEDICAL CARE FOR THE ELDERLY: A STUDY IN KINGSTON, JAMAICA[1]

Denise Eldemire[2]

Health, as defined by the World Health Organization (WHO), is more than the physical condition of an individual; it also refers to a person's mental, social, and spiritual well-being. Just as the definition of health involves a number of sectors, so should the delivery of services. This is particularly true for services to the elderly population, especially in countries that are just developing social service systems.

Although there is great diversity among the elderly in state of health and functional capacity, certain problems are common to the age group as a whole (Eldemire, 1988). These problems are related to income, employment, medical care, housing, nutrition, transportation, recreation, daily activities, and relationships with family, friends, and the community, as well as the degree to which impaired health reduces their independence, incapacitates them, and affects the overall quality of their lives.

Williamson *et al.* (1987) report that old people often do not behave rationally when faced with a disability and may fail to seek appropriate medical help. While the elderly reported respiratory, cardiac, and nervous system disabilities, presumably in the expectation of receiving relief, they failed to report urinary, locomotor, foot, or mental disabilities (depression and dementia), assuming that no relief was available or that discomfort was a part of the aging process. It has also been stated that there is a tendency among the elderly to accept levels of ill health as their "lot" and suffer in silence.

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[1] Originally titled "Medical Care Services for Women over 60: Problems of Access and Adequacy."

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Throughout the Caribbean, the traditional institutional care for the elderly is available in large "infirmaries" that provide bed, food, and custodial care. Grell (1987) estimates that there are presently over half a million elderly West Indians and that there will be 2.6 times that number by the year 2000. Seven countries (Antigua, Dominica, Grenada, St. Vincent and the Grenadines, Jamaica, Trinidad and Tobago, and Barbados) were included in a study of the medical problems of the elderly in the English speaking Caribbean, commissioned by the Commonwealth Medical Research Council. Among the findings were the following:

- Barbados had the greatest proportion of elderly (10%), followed by Jamaica (7.3%). Trinidad and Tobago's elderly population was 4%.
- Emigration in the 1950s and 1960s has depleted the number of persons who would now be middle-aged and has therefore depleted the pool of potential care-givers to the elderly in both Barbados and Jamaica.
- Over the past decade, there have been attempts in Barbados and Trinidad and Tobago to upgrade their city infirmaries into geriatric hospitals; a high standard of care is also achieved in Dominica, where the infirmary is run by a Catholic order.
- Lack of rehabilitation facilities and support services leads to "bed-blocking" by elderly patients in the main hospitals while they await alternative accommodations, to the detriment of patients who may require acute specialized care.

JAMAICAN SITUATION

Jamaica is an island of 2.4 million people, of which 38% are under the age of 15 years. In 1984 the crude birth rate was 25.2/1000 and the crude death rate 5.9/1000. Fertility has fallen considerably over the past 25 years, and in 1983 the total fertility rate was 3.5%, a drop of 36% from the 1970 figure of 5.5%. The decrease has resulted in the narrowing of the population pyramid at its base. In the meantime, the crude death rate has also fallen. Thus, the over-60 population, unlike the younger age groups, has increased rather than decreased and in 1987 accounted for 10.2% of the total population.

Life expectancy at birth has increased dramatically, from 35.89 years for males and 38.20 for females in 1920 to 66.7 for males and 70.2 for females in 1970. In the latter year, life expectancy at age 60 was 17.09 years for males and 19.42 years for females; at age 70 it was 11.20 years for males and 12.78 for females (Department of Statistics).

The above statistics show that Jamaica, which has an approximate per capita income of J$5,704 (US$1,000) and which is usually regarded as a Third World country, has a First World pattern when it comes to the aging of its population. Furthermore, the growth predicted for this segment of the population will be even more dramatic over the next 40 years (Table 1).

Table 1. Population aged 60 and over, Jamaica, 1921-1982 and projections for 2000-2025.

Year	No. aged 60 and over	Percentage of population
1921	52,600	6.1
1943	81,000	6.6
1960	108,000	6.7
1970	151,000	8.4
1982[a]	208,911	9.6
2000	248,000	8.7
2025	551,000	14.6

Sources: 1921-1982—Census data; 2000-2025—Population Aging in Latin America UN E/CEPAL Conf. 74/L3Rev.1 1980.

[a] In 1982, 101,169 of these persons were aged 70 years and over.

Among the elderly, women consistently outnumber men, and the differential increases with age (Table 2). Widows outnumber widowers three to one (37,655 versus 11,218).

Table 2. Population aged 60 and over, Jamaica, 1982.

Age	Males	Females
60-64	26,600	30,900
65-69	24,600	25,700
70-74	20,900	22,900
75+	23,800	33,600
Total	95,900	113,100

Jamaican society, like that of many Caribbean islands, can be said to be matriarchal, and therefore women are the main sources of care for families and in communities. Care of the elderly is therefore very much a women's issue, because not only are there more women than men who are elderly and in need of services, but it is women who have traditionally provided those services.

Health and Social Services

Like many other Third World countries, Jamaica has faced great economic hardship in recent times, and both health and social services have suffered. It is fair to say that while the rudimentary social service infrastructure exists, specific social services for the elderly are lacking.

Health care is provided by the government through a system that relies heavily on primary care. These services are delivered through 357 health centers distributed islandwide, which offer maternal and child health, family planning, curative services, and some home visiting. The emphasis of these services has traditionally been on mothers and children, since the infant mortality rate has only recently been reduced and infectious diseases remain a major cause of morbidity. In addition to the government health centers, health care is also offered by the private sector, but it can be costly.

The government has recently built a model home, the Golden Age Home, for 550 indigent elderly in the capital, Kingston, and plans to upgrade existing homes in the other 12 parishes of the island. However, these homes are costly to run, which is the main restriction on the government's activity in this area. The main problem identified in a recent survey of the residents of the home was lack of activity and stimulation.

AUGUST TOWN HOME

August Town, a community near the University of the West Indies with a population of approximately 7,000 persons, provides a unique opportunity for pilot projects. There are just over 300 elderly in the community. In a survey of care-givers done in January 1988, the main problems they experienced in caring for the elderly were related to lack of understanding of the aging process and a need for advice on nutrition, not to an unmet need for institutional care as had been predicted. In fact, care-givers did not wish to have their relatives removed from the home.

In May 1986, a small, residential, 14-bed, seven-room home for indigent elderly persons unable to support themselves was built in August Town. Seven persons were placed in the home based on recommendations from the August Town Health Center staff (Table 3). Two have since died. Two criteria for admission were (1) an ability to physically look after oneself; (2) prior residence in the area. The reason for the latter regulation was to ensure continuity of the social network.

In May 1987, the Health Center and the community decided to take responsibility for the home and formed a committee. Community resi-

Table 3. Age distribution of residents of August Town home, Kingston, Jamaica.

Age groups	Number	Sex	
		Male	Female
60–69	5	3	2
70–79	1	—	1
80–89	1	—	1
Total	7	3	4

dents visit, do any necessary repairs, and provide the elderly persons with whatever they need. Health Center staff visit the home regularly, and transportation to the clinic is provided when needed. No financing is requested from the government for these services. In addition, the National Council for the Aged provides a hot lunch daily.

Characteristics of Residents

There are both male and female residents. The majority fall under the category "young elderly" (60 to 69 years). It is interesting to note that only one person rated his health "very poor," although only one person had no health problems at all. This finding contrasts with the 57% of persons in another home, the Golden Age Home, who saw their health as very poor. All the persons were able to function independently (Table 4), compared to 33% of persons in the Golden Age Home who needed help. This factor may account for the differences in perceived health.

Table 4. Level of functioning, August Town home, Kingston, Jamaica.

Task	Yes	No	Total
Able to			
Feed oneself	7	—	7
Bathe oneself	7	—	7
Comb hair/shave oneself	5	2	7
Go to the bathroom by oneself	7	—	7
Move about the house by oneself	7	—	7

Community Involvement

Visits were made by members of the committee, the Golden Age Club, Health Center staff, and ministers of various religions, all of whom had known the persons over several years (Table 5). This contrasts sharply with the picture at the Golden Age Home, where the majority (85%) of residents are not visited. Obviously, when persons are nearby they are easier to visit, and it would seem that people will make a commitment to visit friends.

Table 5. Community interaction with residents of August Town home.

Individuals	Residents visited	Residents not visited	Total
Members of organizing committee	4	3	7
Ministers	2	5	7
Community health aides	3	4	7

DISCUSSION

The establishment of the home has had a positive impact upon the delivery of care in the community, since its presence has stimulated the formation of a community-based committee that actively works to meet the needs of the elderly in the home and other elderly in the community, greatly increasing access to care. In other words, working with the seven elderly in the home provided access to the 300 elderly in the community.

Health, as stated earlier, is more than medical care, and the principles of primary health care require that all needs should be met. Cooperation between the community-based volunteers, the health team, and relevant social services has improved the ability to meet needs. The volunteers visit the home on a regular basis and identify problems to the health team and to the social welfare officer.

The committee initiated a series of health talks for the elderly and their care-givers in the community, based on a survey of the care-givers that sought to identify areas in which additional information was needed. These areas were the aging process, nutritional needs, and exercise. The volunteers made all the arrangements, and three meetings were held that each had an attendance of over 100 persons, of which 80% were females.

The volunteers' involvement with community care of the elderly increased further following these health education sessions. During the talks, the elderly who were attending in two capacities (i.e., elderly themselves but also care-givers to other elderly) identified loneliness and social isolation as a major problem and said it affected their health. The volunteers then established a visiting program by matching persons who lived near each other. Subsequent meetings have been held between the health educator and the volunteers, and the visiting program is reported to be working. It is intended that parameters such as blood pressure will be evaluated after six months of these social activities.

The volunteers report to members of the health team regularly and no attempt is made to take the place of the health workers or do their jobs. The members of the health team have welcomed the activity of the volunteers and use them to channel information to the community. Through this mechanism, the community has a voice in the services it receives, particularly in the area of health education. Given the government's cutback in the number of community-based health workers from six to two, the work of the volunteers is essential to fill the gap.

In September 1988, a hurricane devastated Jamaica, leaving many persons homeless, without food, and without utilities. This disaster provided another example of the spontaneous work of the volunteers at a time when no health worker could enter the community due to road damage. The home was immediately visited and the safety of the residents ensured. The volunteers then visited the other elderly in the community and, in addition, took 19 elderly who lost their houses to a church where they were looked after. The volunteers visited the clinic as soon as it reopened to replace medications lost during the hurricane. The group was also used as a channel for relief supplies.

It is important to stress that the interactions between the volunteers, the elderly, and the health team are beneficial to all three groups and to the community as a whole. Persons have a psychological need to feel wanted, and so this service to people and community fills a human need in the volunteer. Awareness in the community of the needs of other people, whether young or old, is increased by these activities, and over time should lead to a more positive attitude toward the elderly.

The elderly residents of the home saw the community as the best place for elderly in need of care. They did not identify the government as being responsible for their care, instead naming children, other relatives, and the church. Interestingly, regardless of who they had identified, they said it was neighbors they called if they were in need.

The elderly continue to interact with the community and appear satisfied with their lives. They do not seem to resent their "retirement," and see their children and neighbors as being their main sources of support.

The majority of the residents saw their health as being good. All residents visit the clinic for medical attention, the females much more frequently than the males. The clinic staff also visit the home regularly. One resident often has difficulty getting her anti-Parkinson's disease drugs, and the clinic assumes responsibility for getting them for her.

The health delivery system, in helping to meet the social and mental needs of these persons as well as their medical needs, is truly demonstrating the delivery of "health care."

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NUTRITIONAL STATUS, SOCIOECONOMIC ENVIRONMENT, AND LIFESTYLE OF THE ELDERLY IN AUGUST TOWN, KINGSTON, JAMAICA

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RATIONALE OF STUDY

At present there are more than 376 million people in the world aged 60 and above. This number is expected to rise to 590 million by the year 2000, and it is believed that 302 million of these will be found in developing countries.

Within the English-speaking Caribbean, the 1970 census showed that overall, between 8.8% and 9.8% of the population of the islands was aged 60 and over. Thus, there were over half a million elderly West Indians in 1970, and it is estimated that the elderly population is likely to number 2.6 times more by the year 2000.

Because of the large numbers of the aged, their rapid increase, and the changing objective conditions, there is a great need for planning for the level and types of services required by older persons. Thus, there is also an urgent need for surveys on all aspects of the health of the elderly.

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This study is an attempt to investigate in depth the nutritional status, socioeconomic environment, and lifestyles of an elderly population in the small urban area of August Town in Kingston, Jamaica.

OBJECTIVES

The general objective was to assess the nutritional status of the elderly population (65 years and over) in August Town and to determine the relationship between their nutritional status and lifestyle.

Specific objectives were the following:

- To describe the general characteristics of the study population;
- To determine their economic conditions;
- To determine their social conditions and social support systems;
- To describe their dietary habits;
- To assess their health and nutritional status; and
- To determine the relationship between nutritional status and lifestyle.

MATERIALS AND METHODS

Study Population

August Town-Hermitage are small communities with a total population of 7,455, about a mile west of the University of the West Indies (Mona Campus), Kingston, Jamaica. The Department of Social and Preventive Medicine (DSPM) and the University Hospital of the West Indies provide primary and secondary health care, respectively, to the people of these communities. Because of the continued interest of the Department and the proximity of the communities to the DSPM and the Caribbean Food and Nutrition Institute (CFNI), it was decided that a study would be conducted in these communities. However, because of constraints of time and resources, only the people 65 years and older in August Town were actually studied.

August Town contains two-thirds of the population of the August Town-Hermitage area. It is divided into two sections—the older part consisting mainly of large parcels of land with a common address on which are situated many houses and tenements called "rent yards," and the newer part consisting mainly of government housing projects as well as privately built houses. During the 1950s several housing projects were erected by the government. Some were built as one-room houses with very low rents and others as two- to three-room houses that were available for long-term purchase. Thus, the area consists mostly of persons from low and lower-middle socioeconomic groups. According to the census carried out in April 1984 by community health aides working in the area, the population was 4,396.

In the community are a few self-employed persons (commercial traders, vendors, butchers, and bartenders) and also some employed civil service workers, typists, etc., who all belong to the lower-middle class socioeconomic group. There are also several unskilled laborers, such as domestic helpers, porters, and some casual laborers. Since the closing of the local shoe and plastic factory in 1979, a large portion of the people remain unemployed, and there are also several school drop-outs who are idle. Other people receive remittances from relatives abroad. Sharing of foodstuffs among neighbors is an important asset in this community.[6]

Study Design

The following types of information were collected during June and July 1984:

- Demographic and living conditions;
- Socioeconomic conditions;
- Dietary habits;
- Health status as reported by people;
- Anthropometric measurements;
- Blood pressure and sugar and albumin levels in urine;
- Hematological profile and blood chemistry.

Information on the first four topics was collected through house-to-house individual interviews based on a questionnaire prepared for that purpose. To prepare the questionnaire, visits were made to August Town with the community health workers who serve the area, records were reviewed at the DSPM Health Center for health profiles, and discussions were held among the investigators and the statisticians at both CFNI and DSPM.

One of the investigators together with a community health worker from the DSPM who works and lives in August Town administered the questionnaire. The community health aide (CHA) had been trained in techniques for collecting the information on the questionnaire.

In the second phase of the study, a team consisting of two of the investigators and two trained community health aides carried out the anthropometric measurements, measured blood pressure, and tested urine. Weight and height were taken by one CHA while the other took blood pressure and examined urine. In doubtful cases, measurements were checked by the medical officer. Most of the measurements were done at the Community Center building, where people were asked to visit at specific times.

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[6] Gregory, Dorothy, Department of Social and Preventive Medicine, University of the West Indies, Kingston, Jamaica. Personal communication.

For the third phase of the study, a 20 ml blood sample was collected from all participants. This procedure was also carried out at the Community Center building. Those who could not or preferred not to come to the Community Center for anthropometric measurements and/or blood drawing were visited at their homes and the procedures were carried out there.

Hematological investigations (hemoglobin, serum iron, total iron binding capacity) and blood chemistry estimations (serum calcium, serum phosphorous, alkaline phosphatase, and serum albumin) were carried out at the Hematology and Chemical Pathology Departments, respectively, of the University Hospital of the West Indies.

Methodologies for Nutritional Investigations

A beam balance was used for measuring weights. Subjects were weighed with their clothes on, but shoes off. The height of each person was also recorded, using a vertical measuring rod attached to the beam balance. A Lange caliper was used to measure the skin fold at the back of the left mid-arm. Mid-arm circumference was also measured using a fiberglass tape. Blood pressure was taken with a mercury sphygmomanometer. Screening for sugar and albumin was done using "uristix."

Analysis and Interpretation of Data

The data collected on lifestyle, anthropometric measurements, and blood analysis were coded and entered into a microcomputer at CFNI. They were analyzed using programs available at that Institute.

FINDINGS

General Characteristics of the Study Population

The total population of people 65 years old and above in August Town was 197. Of those, 154 (78.2%) were interviewed, constituting the study population. Sixteen of those not interviewed were either too sick or senile. The other 27 could not be contacted because they were working and not at home. Of those who could not be interviewed, 23 were males and 20 females. The following results are based on the 154 interviews.

Age and Sex. The study population was 74% female and 24% male. The majority were of African descent. Table 1 shows the age and sex distribution of the study population. The general pattern of the male to female ratio held true for each age group.

Table 1. Age and sex distribution of the study population, August Town, Kingston, Jamaica.

Age groups (years)	Sex				Total	
	Male		Female			
	No.	%	No.	%	No.	%
65–69	9	(28.1)	23	(71.9)	32	(100)
70–74	14	(26.4)	39	(74.6)	53	(100)
75–79	5	(17.9)	23	(82.1)	28	(100)
80–84	5	(25.0)	15	(75.0)	20	(100)
85+	4	(19.0)	17	(81.0)	21	(100)
Total	37	(24.0)	117	(76.0)	154	(100)

Religion. Almost everyone belonged to the Christian faith, with one-third being Baptist and another 17% Anglican.

Marital status. A large percentage (56.5%) of the elderly were married, widowed, divorced, or separated. Only 3.5% of the population reported common-law marriage, while 40% were single.

Living children. Seventeen percent of the respondents had one living son or daughter, 33% had two to five living children, and 15% had more than six living children. Thirty-five percent had no living children.

Socioeconomic Environment and Lifestyle

Place of residence. The family appeared to be the main support for the elderly, since 70% lived with their sons, daughters, or spouse, and only 24% lived alone. Living with family was defined as living with any relative (not just son, daughter, or spouse). The probability of living with family was directly proportional to the number of living children. This arrangement was more common for the female elderly than for males.

Position of the elderly in the family. Of the large percentage who lived with their sons or daughters, 58.4% reported being the head of the household. This was true even if their sons or daughters were adults. This situation was more frequently the case for the male elderly than for females. If the husband and wife lived together, the husband was reported as the head of the household.

Composition and characteristics of the elderly's households. Only 24% lived alone. Another 30% lived with one other person, while 21% lived with six or more persons. Likewise, 21% of the elderly lived in households with children under five years of age, and another 34% lived in households with school-aged children. Thirty-six percent lived with one, two, or three other adults, and 8% lived with four or more adults. For 38%, they were the only elderly person living with the family.

Housing. Only 25% of the study population appeared to live in relatively crowded conditions, and 54% of the elderly lived in houses which had three rooms or more.

Ninety-eight percent reported having kitchen facilities, 67% inside and 31% outside the house. In addition, 55% had refrigerators in the house and 64% had stoves (electric, gas, or kerosene), but 73% also had charcoal stoves for cooking.

Toilet facilities were available to 98% of the elderly, and 97% also had access to piped water in or outside the house. Two percent used public standpipes.

Only 20% of the elderly reported having kitchen gardens, which were largely used for growing vegetables (80%) and beans and peas (42%). However, 78% reported having fruit trees in their yards, and 15.6% had breadfruit trees.

Economic status. Most (85%) of the elderly people held no paying job, but 7% held full-time jobs, and another 8% held part-time jobs. Those who worked were mostly storekeepers, vendors, or domestic workers.

A variety of income sources were depended upon by the elderly people. Chief among them were family support (38%) and government welfare (42%) (Table 2). Seventy-four percent received less than J$20 (US$5.00) a week and 12% received more than J$40 per week. For the majority (84%) who received welfare/government support, it amounted to less than J$20 per week.

Money spent on food and rent. No money was spent on food by 32% of the elderly people. Another 31% spent less than J$20 a week, but 14%

Table 2. Financial support of the elderly in August Town, Kingston, Jamaica, 1984.

	Yes		No	
Sources of income	No.	%	No.	%
Wages	19	(12.3)	135	(87.7)
Family	59	(38.3)	95	(61.7)
Welfare/govt.	65	(42.2)	89	(57.8)
Other	34	(22.1)	120	(77.9)

spent more than J$50 per week on food. In contrast, 87% of the respondents did not spend any money for house rent. Six percent spent less than J$25 per month, and only 1% spent more than J$100 per month.

Physical exercise and activities. The majority (84%) of the elderly in this study were ambulatory. Sixty-two percent walked occasionally and 19% walked daily. Very few were involved in gardening. One-third did house-cleaning and 55% washed their own clothes.

Social life. Friends, neighbors, and religious activities constituted the largest part of the social support system. Forty-nine percent of the elderly said they never felt lonely, and another 45% said that they sometimes felt lonely. Only 7% said they were often lonely. Very few elderly persons were involved in organized community activities.

Dietary Habits and Practices

Forty-nine percent of the elderly cooked for themselves. Of those who did not cook, 78% had meals provided by their families, 8% had "helpers" to cook, and 14% had other meal sources. For obtaining groceries, 42% did their own shopping and another 48% said that their family did their shopping. Seven percent reported being assisted by friends and neighbors, and few other sources of help were mentioned.

Half of the study population reported eating two meals per day, and the other half reported three. The evening meal was described as the main meal by 93% of the elderly. Although 36% ate alone, 60% ate with their families, and only 4% ate with others. Regarding food preferences, 82% said that they did not dislike certain kinds of food. Appetite was described as fair to good by 97%. Only 4% reported a poor appetite.

Seventy-four percent reported that they never drank alcoholic beverages. Another 23% said they seldom drank. Only 3% reported that they drank more than two to three times per week.

Data collected by using 24-hour recall indicate that the diet of the elderly in August Town was grossly deficient in most nutrients. To supplement 24-hour recall, a food frequency history was also taken for selected major food times. Bread, meat or fish, and rice were the most frequently consumed items. The next most frequently consumed were vegetables and grain products. High-fiber items were reported often. Callaloo *(Amaranthus)* was frequently eaten, while milk was not commonly used. Items like wheat flour dumplings and ackee *(Blighia sapida)* were eaten very infrequently.

Reported Health Status and Health Service Utilization

When the elderly were asked about their health, 11% described themselves as being in good health and 80% said they were in fair health. Only 9% described their health as bad. However, upon inquiry about specific illnesses, a very significant number reported suffering from one or more diseases (Table 3).

Table 3. Illness patterns reported by the study participants.

	Percentage of population	
Illnesses	Suffering from disease	Presently taking medication
High blood pressure	52.6	51.3
Diabetes	14.9	14.3
Arthritis	44.2	28.6
Heart disease	16.2	12.3
Other illnesses		
1 type	41.5	19.5
2 types	44.2	
3 types	49.0	

It is obvious from Table 3 that a high proportion of those who reported suffering from specific illnesses also mentioned taking medication. Thirty-one percent took home remedies.

A large percentage of the elderly attend the DSPM clinic for their health care. Seventy percent of them had visited the clinic within the previous four months. Of those who reported any illness, 72% had attended the clinic within the previous month. It is important to point out that the Department of Social and Preventive Medicine also provides health care services at the homes of those unable to attend the clinic.

Measured Nutritional and Health Status

Anthropometric Measurements

Anthropometric measurements were taken on approximately 88% of the people who responded to the lifestyle questionnaire. Table 4 gives the mean values and the standard deviations of the four measurements taken.

Table 4. Mean values of anthropometric measurements for elderly residents of August Town, Kingston, Jamaica, 1984.

Measurements	Sex	Mean	Standard deviation
Weight	Male	61.0 kg	± 9.9 kg
	Female	60.0 kg	± 13.6 kg
Height	Male	165.6 cm	± 11.0 cm
	Female	154.9 cm	± 6.3 cm
Arm circumference	Male	26.5 cm	± 4.1 cm
	Female	28.1 cm	± 5.2 cm
Skin fold thickness	Male	7.5 cm	± 0.59 cm
	Female	18.8 cm	± 1.10 cm

Weight-for-height is a useful indicator of nutritional status. Table 5 shows the different percentages of standard weights-for-heights by which persons were classified. Thirty-eight percent of the females and 3.3% of the males were obese. However, 5.1% of the females and 13.3% of the males were undernourished.

Table 5. Percentage of standard weight-for-height, by sex, among elderly study population in August Town, Kingston, Jamaica, 1984.

Percent of standard weight-for-height	Male		Female		Total	
	No.	%	No.	%	No.	%
Under 80	4	13.3	5	5.1	9	7.0
80–120	25	83.3	56	57.1	81	63.3
120–140	1	3.3	22	22.4	23	18.0
Over 140[a]	0	0.0	15	15.3	15	11.7
Total	30	(100)	98	(100)	128	(100)

[a] Those over 140% above the reference standard were considered grossly obese.

Hemoglobin and Biochemical Examinations

Hemoglobin tests were done on 121 persons. Thirty (24.8%) who showed low hemoglobin levels were further examined with a more detailed hematological profile (Table 6). Among those anemic, 60% could be classified as iron deficient. Serum albumin was low in 13.3% of males and 5.7% of females.

Table 6. Iron deficiencies among the elderly, August Town, Kingston, Jamaica, 1984.

Iron deficiency measurements	Lower limit of standard	% Males below limit	% Females below limit
Serum iron	11 μmol/l	28.6	27.3
Iron binding capacity	45	14.1	9.1
Percentage saturation	25%	71.4	56.3

Thirty-four percent of females and 27% of males had low calcium levels. Very few people had low serum phosphorous, and none had low alkaline phosphatase levels. These findings indicate fairly good bone health relative to age.

Other Health Parameters

Two measurements useful for determining general health status were blood pressure and urine examination for albumin and sugar. Blood pressure was measured on 131 persons (85%). Systolic blood pressure above 160 mm of Hg was found in 14% of the males and 37% of the females. However, 29% of the males and 23% of the females had diastolic readings above 100 mm of Hg. Four percent of the subjects were positive for sugar and 13.3% had elevated levels of albumin.

Relationship between Nutritional Status and Lifestyle and Health Indicators

Nutritional status did not show any marked variation between age cohorts among the elderly. There was more obesity and less undernutrition among the people who had two or more children. The place of residence showed no relationship to the nutritional status. Those who had kitchen gardens were less likely to be obese than those who did not. A large percentage of the malnourished were on welfare (36%). However, 60% of those who were obese depended on their family for support (Table 7).

Table 7. Nutritional status and source of income.

Percent standard weight-for-height	Source of income									
	Wages		Family		Welfare		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Under 80	2	18.2	3	27.3	4	36.4	2	18.2	11	100.0
80–120	11	11.9	25	27.2	40	43.5	16	17.4	92	100.0
120+	3	7.5	24	60.0	8	20.0	5	12.5	40	100.0

When nutritional status was tabulated against blood pressure, it could be seen that obese persons had high systolic blood pressure much more frequently than did underweight persons (Table 8). However, no such relationship was observed between nutritional status and diastolic blood pressure (Table 9).

Table 8. Nutritional status and systolic blood pressure.

Percent standard weight-for-height	Systolic blood pressure							
	<140 mm Hg		140–160 mm Hg		>160 mm Hg		Total	
	No.	%	No.	%	No.	%	No.	%
Under 80	3	33.3	3	33.3	3	33.9	9	100.0
80–120	26	32.1	30	37.0	25	30.9	81	100.0
Over 120	4	10.8	18	48.6	15	40.5	37	100.0

Table 9. Nutritional status and diastolic blood pressure.

Percent standard weight-for-height	Diastolic blood pressure					
	<100 mm Hg		>100 mm Hg		Total	
	No.	%	No.	%	No.	%
Under 80	7	77.8	2	22.2	9	100.0
80–120	64	79.0	17	21.0	81	100.0
Over 120	24	64.9	13	35.1	37	100.0

A history of diabetes showed no relationship to nutritional status. A larger proportion of obese people complained of arthritis than those who were normal or underweight (Table 10). A history of heart disease was also more prevalent in obese persons than in those normal or underweight (Table 11).

Table 10. Nutritional status and arthritis.

Percent standard weight-for-height	Yes		No		Total	
	No.	%	No.	%	No.	%
Under 80	1	25.0	3	75.0	4	100.0
80–120	33	57.9	24	42.1	57	100.0
Over 120	26	76.5	8	23.5	34	100.0

Table 11. Nutritional status and heart disease.

Percent standard weight-for-height	Yes		No		Total	
	No.	%	No.	%	No.	%
Under 80	0	0.0	4	100.0	4	100.0
80–120	10	19.2	42	80.8	52	100.0
Over 120	9	37.5	15	62.5	24	100.0

Neither hemoglobin, serum calcium, nor serum albumin levels showed any correlation with nutritional status.

DISCUSSION

Systematic studies on the elderly population in the Caribbean are rare. This study highlights several features of the social, economic, health, and nutrition situation of the elderly in a small urban community in Kingston. It is important to know these features in order to plan services for the elderly. In addition, it should be noted that small studies such as this one, though not providing definitive answers, are highly valuable for examining potential relationships between variables and highlighting general trends. Definitive answers will require larger studies planned along the lines mapped out by the smaller studies.

The sex ratio of the elderly in August Town was somewhat skewed compared to the general elderly population in Jamaica. While in Jamaica the population of people 65 years of age and older in 1982 was 7.3% of the total, of which 54% were female, in August Town only about 5% were 65 and above and approximately 74% were females, indicating a trend towards female longevity.

Since 88% reported affiliation to some religious denomination and 24% reported regular involvement in religious activities, religious organizations provide a possible avenue through which programs could be channeled.

Marriage appeared to be a rule rather than an exception, as 56% reported being or having been married and only 3.5% reported being in a common-law union. This may account for the large percentage of the elderly being cared for by their families. The 40% of singles may include a substantial number of people formerly in common-law partnerships that have ended due to death of one of the partners. Sixty-five percent had living children. The family provided the primary social support system for the elderly, since 70% of them lived with their families, of which they formed an integral part. Eighty-three percent of the males and 51% of the females reported themselves to be the head of the household, even if they lived with their adult children.

The physical living conditions of the elderly were satisfactory, as indicated by a low degree of crowding, the widespread availability of piped water for drinking and washing, and toilet and cooking facilities.

Some form of economic support, though very small, was available to 96% of the elderly, mostly from family, welfare, or other government sources. In addition, they were provided with indirect household support, 87% paying no rent and 32% not spending any money on food. It is apparent that without support from their family, the personal income of most elderly persons would not have been enough to meet their needs. Most of them said they eagerly awaited the forthcoming Food Stamp Program.

Most of the elderly were ambulatory and active. A large percentage of them walked regularly and even daily. A large percentage also did cooking, washing, and house-cleaning. Very few were involved in organized activities, such as those offered by clubs and associations. Over half lived in households with preschool and school-aged children, and very few complained of being lonely. All these features indicate that family and the community provided the main social, economic, physical, and mental support to the elderly in August Town.

Although dietary investigation by means of a 24-hour recall (which is known for its inadequacies) showed deficiencies in both protein and energy intake, undernutrition was not a major problem. Only 7.0% were undernourished according to weight-for-height criteria. A large percentage showed very low skin fold thickness. Skin fold measurements in the elderly are fraught with problems, like decreases with age in skin fold thickness for the same body density and in compressibility of skin, which varies with the individual and thus creates a lack of a "reference" standard against which to evaluate the measurements. Obesity, rather than undernutrition, was a significant problem for the elderly in August Town.

Based on 24-hour recall, the daily dietary requirement met by the highest proportion of the elderly was that of iron. Food frequency recalls also indicated a good consumption of iron-containing foods. However, low hemoglobin levels were found in 25% of the elderly tested, the majority of whom were iron deficient. In addition to functional explanations such as iron absorption problems, the effects of the aging process and of overt or hidden diseases on hematologic measurements must be taken into account when interpreting such data. Low serum albumin is indicative of malnutrition, but a problem may be present even if the albumin concentration is normal or increased. This is based on the fact that while kwashiorkor malnutrition almost always shows low serum albumin, the marasmic type usually shows a normal or only slightly decreased level. Thus, in this study at least 13% of males and 6% of females showed signs of malnutrition. The same percentages of elderly also showed weight-for-height below 80% of the reference standard.

Major health problems in the elderly in August Town were chronic diseases: hypertensive disease, diabetes, arthritis, and heart disease. The conditions reported by the people themselves were confirmed, since a high proportion of the study population attended the clinic run by the Department of Social and Preventive Medicine and were keenly aware of their medical condition. High rates of hypertensive disease was also confirmed by measurement of blood pressure, but the prevalence was not as high as the histories had indicated, perhaps owing to the fact that a large percentage of hypertensives and diabetics were on medication. However, dietary therapy did not receive adequate attention. These diseases were definitely more prevalent among obese persons.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

Specific

1. A pilot project on health care for the elderly—one including not only the care of the sick at the clinic and hospital but, more importantly, health care at the community level—should be developed in August Town. In this regard, a multidisciplinary community health care group should be formed to look after the social, mental, and physical health of the elderly at the community level. Such community groups should consist of health care personnel, representatives of other sectors (government

and private) and of voluntary groups, and representatives of the senior citizens themselves and should look into problems such as:

(a) Caring day-to-day for those who are very old and cannot take care of themselves. This can be done by healthy senior citizens or by younger volunteers;
(b) Strengthening organized activities such as "Golden Age Clubs" through increasing the membership and the variety of activities;
(c) Organizing health education activities for the elderly;
(d) Strengthening health maintenance and rehabilitation activities within the community, along with providing care for minor illnesses, e.g., checking blood pressure, checking urine for sugar, and organizing physical activities.

2. Further training should be provided to community health aides in matters concerning the aged so that they can encourage and educate older people to care for themselves. Since a large proportion of the elderly are obese and suffer from related chronic diseases, dietary management of these diseases should be a major part of this training.

3. Data on dietary intake gathered for this study were inadequate. Utilizing the services of community health aides, 24-hour recall interviews on food intake should be repeated on two or more occasions. This knowledge will greatly strengthen our ability to provide adequate dietary advice to the community.

General

1. Two similar studies being planned—one in a lower socioeconomic group community in downtown Kingston and another in rural Jamaica—should be conducted in order to determine the general pattern of health and nutritional problems of the elderly in the country, the lifestyle variables, and the potential relationships between variables.

2. Based on the results of these studies, a national survey of some of the important parameters should be conducted in order to develop national programs for the elderly. Such studies will greatly strengthen and provide a means of evaluating the national Food Stamp Program for the elderly presently under way in Jamaica.

3. The family appeared to be the main support for the elderly in August Town. If this proves to be the trend throughout Jamaica, efforts equal to the ones to build old-age homes should be made to provide incentives to those families that take care of their elderly. This will provide

encouragement to the family support system for the elderly and save it from crumbling under socioeconomic pressures, and it will be economical for the nation in the long run.

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Psychosocial Aspects

SOCIAL POLICIES AND PLANNING FOR MIDLIFE AND OLDER WOMEN IN LATIN AMERICA: AN INTERNATIONAL APPROACH

Jacques du Guerny[1]

THE AGING OF POPULATIONS IN LATIN AMERICA

Until relatively recently in most developing countries, problems associated with aging were generally perceived as issues to be resolved at the level of the individual and his or her family. However, now that the aging of populations in developing countries is becoming significant and the proportion of the total population represented by the elderly is increasing, issues such as public health expenditures and dependency ratios (i.e., the increased burden placed on younger adults) must be addressed.

When a population starts to age, the aging individual can no longer be considered in isolation because the person is involved in all the issues raised by an aging population. Families often have difficulties coping with the elderly individual; but in some cases, there is no family to care for the elderly person. Each new generation has to deal with a different pattern of populational aging. Thus, social planners can work from various perspectives: to tackle immediate problems or engage in long-term planning.

What is the status of the aging of the population in Latin America? At the beginning of the 1980s, it was thought that the only Latin American countries really affected by this process were those of the Southern Cone of South America (Argentina, Chile, Paraguay, and Uruguay). The population of the elderly in the rest of the Region was very low (slightly over 5%; that is, for every 100 inhabitants, five were over 60 years old).[2] This proportion is comparable to that in Africa and parts of Asia.

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The World Assembly on Aging concluded in its introductory document (A/CONF.113/4) that this situation was not stable and that in other subregions of Latin America the populations would age in the future, although at different rates.

For Latin America as a whole, the proportion of elderly of both sexes in the total population is projected to increase from nearly 7% in 1985 to over 12% in 2025 (United Nations, 1988). The total number of elderly of both sexes would more than triple during the period 1985–2025 and will approach 100 million in 2025. In that year, it is projected that 54% of these 100 million elderly will be women (see Table 1).

Table 1. Estimated and projected female population (in thousands) at ages 45 and above in Latin America, 1975–2025.

Age groups[a]	1975	1985	2000	2025
Women at midlife (45–59 years)	16,103	20,545	32,196	63,347
Older women (60–74 years)	8,484	11,247	16,952	39,458
The very old (75+ years)	2,216	3,311	5,685	12,893
Total	26,803	35,103	54,833	115,698

Source: *World Demographic Estimates and Projections, 1950–2025*, United Nations, 1988.

[a] The terminology used is the one used by AARP. The United Nations has adopted 60 as the age at which the "elderly" group begins.

The diversity found in the aging rate of the populations of Latin America can be seen in the situation of the elderly themselves. The elderly women will have different situations: married, widowed, or single; with caring families or essentially alone in the world; urban, rural, or migrant. Many will be illiterate, and their health, housing, and living conditions will vary. But on a regional basis they will be affected by factors shared by the countries, such as the high level of urbanization and common cultural aspects. There is no simple or single solution to problems of the elderly in Latin America, but it is possible to examine the process through which solutions can be found. Guidelines for policies and programs already exist,[3] and they should be analyzed with a view toward their relevance to the situation of older women in the Region.

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[2] The definition "age 60 years and above" was adopted by the World Assembly on Aging for the elderly.

The Cohort Approach to Analysis and Planning

The present relatively low proportion of the elderly in many Latin American countries and the time-lag before the population aging process takes off make it possible to prepare systematically for the future. Taking advantage of this fact, and in the light of the international guidelines adopted in recent years, the present paper draws attention to the usefulness of the *cohort approach* to social policies toward aging women. In contrast to the technique of considering the situation of an age group at a specific point in time, the cohort approach bases its analysis on following each particular generation or age group over time.

One important advantage of the cohort technique is that it focuses attention on the principle of *participation*, which is stressed in all the relevant international guidelines. Each cohort can be encouraged to consider its own future. For example, 60% of the group of women 45–49 years of age in Latin America in 1990 is projected to survive to age 75–79 in the year 2020. Many questions can be raised in relation to this projection: Could this rate of survivorship be improved?[4] If so, through what kinds of policies and programs? What sort of life can survivors expect to enjoy, particularly in respect to economic security? What will the wider implications be for society and especially for younger women, who have traditionally assumed the role of primary care-giver in the family?

Such questions can open a dialogue between generations concerning transfers of wealth, the priority accorded to consumption versus investment in the future, and the role of each generation in changes in the age structure of the population.[5] Furthermore, such a dialogue would avoid what appears to be, in the short term, divergent interests that could polarize the generations. Given that aging is a universal experience, such a dialogue could promote the perception that it is in the collective self-interest to seek solutions to universal problems. The cohort approach thus promotes not only individual but also collective participation and negotiation.

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[3] Vienna International Plan of Action on Aging, 1982; World Program of Action concerning Disabled Persons, 1983; The Nairobi Forward-looking Strategies for the Advancement of Women, 1985.

[4] If the survivorship rate were raised 10%, from 60 to 70%, the cohort of women aged 45–49 in 1990 would number 6.3 million instead of the projected 5.4 million in 2020—an increase of over 16%—with implications for dependency ratios, health costs, and housing.

[5] Ideally, each new generation (or cohort) should be aware that its fertility will have an impact on the aging of the population. One can imagine that, just as individuals (or couples) plan their future through family planning, this concept can be enlarged to population planning based on each generation thinking through the possible consequences of its behavior and organizing its life cycle accordingly.

One further important preliminary question needs to be raised: Why should aging women be discussed in isolation from aging men? Should not aging be seen as gender-neutral? Is there not a danger that splitting the potential collective strength of the elderly between men and women will result in neither sex being able to safeguard its common or specific interests?

The simple answer is no. Due to their differing histories and the differing degrees of inequality they have confronted, each cohort of women and men faces aging under different conditions; but, in each case, conditions are generally more unfavorable to women. The problems that arise with aging are not usually intrinsic to women (as in the case, for example, of hysterectomy); they are more often simply increased in degree or frequency, e.g., widows are more common than widowers, women suffer more than men from disability, widows generally have to live on a reduced pension (if any), and elderly women appear to be more frequent victims of violence. These factors cannot be ignored, and of particular concern is the loneliness caused by the loss of family, friends, and economic support and through which women become invisible and insignificant to society at large. However, when analyzing issues relevant to either males or females, it is advisable to keep in mind the many issues that concern both sexes, in order to avoid artificial distinctions.

A POLICY FRAMEWORK: INTERNATIONAL INSTRUMENTS AND AGING IN WOMEN

International instruments—including plans, agreements, and strategies—represent the global perception of issues and the consensus on the type of action they necessitate. For this reason it is useful to examine the instruments relevant to aging and elderly women. A United Nations report, submitted in 1986 to the Commission on the Status of Women, analyzed the relevance of two international instruments, one on aging and the other on women (United Nations, 1986). The present analysis stresses the approach of these two instruments plus one other to issues of relevance in social planning.

The Vienna Plan of Action on Aging

The conceptual framework of the Vienna Plan of Action (VPA), which was adopted in 1982, is particularly relevant to the cohort approach. The VPA examines aging from several points of view, each complementary to the other. The aging of both individuals and populations is seen as a continuing process of change; the elderly at any point in time are perceived as the result of these interdependent processes of individual aging and the collective history and thus have a variety of needs.[6] Many of the recommendations of the Vienna Plan of Action can be used as guides to policy and long-term planning. For example, in the section on individual health and nutrition, recommendation 1 focuses on the types of care needed to deal with the current health problems of the elderly, but recommendation 3 focuses on early diagnosis and preventive measures, thereby introducing a time dimension. Recommendations 11 and 14 focus on assessment of the health needs of the elderly and the antecedents to disorders common among them in order to more effectively plan preventive measures.

One limitation of the VPA is that the relationship between the aging of populations and the demand and supply of health care service is not adequately covered. However, since the analogous relationship between aging and pension systems and related social security issues is dealt with in a comprehensive manner, it can serve as a starting point for analyzing issues relative to health and other areas.

On the specific subject of the aging of women, the VPA provides examples of needs and underlines some particular areas of concern, such as the increasingly skewed sex ratio as a population ages, or the particular overall vulnerability of elderly women as evidenced by their high rates of poverty. The subject is not systematically approached throughout the VPA, however, and the Plan is weak in that respect. The reference in the VPA to the family is particularly relevant to the cohort approach in view of the changing status of women, which can be expected to reduce their "traditional role as care-takers of older family members" (paragraph 66). The Plan notes that each new generation of women is different in its behavior and activity, and that modified or replacement systems of support (other than women care-takers) need to be explored if women are not to be the victims of their change in status at a later stage in their life cycle. The VPA implies that the gains in status made by women in their early- and mid-adult lives could be lost at a later stage: i.e., their daughters would no longer be available to take care of their needs. Therefore, there should be shared family responsibilities towards elderly parents, or a mixture of family and community or state support systems.

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[6] See in particular para. 31(a) and (d) of VPA.

Perhaps the major objective of the VPA was to place the issue of aging on the agenda of the global community, pointing out its relevance to both industrialized and developing countries. It would have been unrealistic to expect it to consider in a comprehensive and in-depth manner specific issues relating to aging in women. In the final analysis, the major contribution made by the VPA was to encourage a sophisticated approach to all issues of aging (including those for women) through recognizing the multiple dimensions of the issues to be dealt with, which range from the problems raised by the aging of populations to the various needs of the individual elderly, such as health care and housing. However, it remains for the international community to devote further study to the implications of the aging of populations as that process relates to other changes in such areas as technology and lifestyle.

The United Nations Decade for Women and the Nairobi Forward-looking Strategies

The Forward-looking Strategies, adopted in 1985, were the culmination of the United Nations Decade for Women, which was launched at the 1975 Mexico World Conference of the International Women's Year. The evolution of perspectives on aging women reflects some of the changes in thinking that occurred over the period.

The report of the Mexico Conference devoted only a single paragraph of three lines to the question of elderly women, in a section entitled "other social questions." At that time, the needs of the elderly were perceived in terms of the problems of old age, rather than of aging, and were treated essentially as a welfare question. Indeed, the elderly are not mentioned at all in the section on "the family in modern society," which focuses mostly on younger women, particularly in their roles as wives and mothers. Resolution 13 of the Mexico Conference focuses on social and family security for women, "including the elderly and handicapped." It should be noted that the same resolution recommends (paragraph 6) further study of measures for achieving the "reintegration into socially active life" of elderly women, thus opening the door for a broader planning approach. In fact, if appropriate measures are taken early enough under the cohort approach, aging women might never be excluded from active life. Whatever its specific shortcomings, it could be said that the major objective of the Mexico Conference—to place women on the agenda of the international community (just as the Vienna Plan of Action had done for the elderly)—was achieved.

Five years later (1980) at the Copenhagen Conference, which was the first successful attempt to deal with the problems faced by women from a global perspective, the problems of elderly women did not receive any more attention than in Mexico. Again, elderly and disabled women were considered together. The Conference was, however, more specific; its resolution 4 requested that the issue of elderly women be given special attention at the World Assembly on Aging.

At neither Mexico nor Copenhagen were women's problems addressed with a view toward the life cycle: that is, aging was not recognized as a process in every woman's life. A woman may be elderly, but that stage was not afforded the same degree of focus by the conferences as were the problems of young and middle-aged adult women, such as education, employment, and equal rights. The observation that "middle age marks the point at which women cease to be 'relevant' as women and start instead simply to be old" (Russell, n.d.) seems to be applicable to the manner in which the issue was treated at both conferences.

In the Forward-looking Strategies adopted at the Nairobi Conference in 1985, an entire section was devoted to elderly women (paragraph 286). This section emphasizes the significance of the problems affecting elderly women, which stem from their longer life expectancy, and elaborates on the welfare and particularly the economic dimensions. Older women are perceived as a "vulnerable" group, and issues of concern to them are discussed in a section of the chapter entitled "Areas of Special Concern," as are issues of concern to abused women, refugees, and other groups for which policies tailored to specific needs are required. Most of the groups of women considered in this chapter of the Nairobi Strategies have in common being accidental victims of events that have resulted in their becoming refugees or victims. The inclusion of a natural stage of life (aging) with these other problems could lead to misunderstanding, tainting aging with negative connotations by casting elderly women as cut off from the mainstream of events and developments. It would have been preferable to separate these women into several categories. On the positive side, for the first time, an international instrument for women mentions aging as a process, as a challenge that needs to be faced early in life. Also very important from a social planning perspective is the prescription that interventions to improve the quality of life of the elderly should take place at earlier stages. Despite this new orientation in the Strategies, the overall approach is still, essentially, a welfare approach, appropriate for a so-called vulnerable group that happens to be "elderly," as though this were not through a natural process. The Nairobi Strategies, nevertheless, constitute an improvement over the Mexico Plan in this area.

It should be noted that in the normal course of events, issues are typically first identified and isolated and only later analyzed and treated in a comprehensive or sophisticated manner. The recent identification of elderly women as a special concern suggests that the issue is still in the preliminary phase.

Following the Nairobi Conference, the Commission on the Status of Women discussed the problems of elderly women at its thirty-first session in 1986. The Commission recommended that the Vienna Plan of Action and the Forward-looking Strategies be brought into harmony. The Economic and Social Council (ECOSOC) endorsed the Commission's position in its resolution 1986/26, and no further action has been taken by the Commission, although its priority theme for 1991 is equality for vulnerable women.

The World Program of Action Concerning Disabled Persons

The third major international instrument relevant to aging women is the World Program of Action concerning Disabled Persons, adopted in 1983. In it, disabled *women* are treated separately from the disabled *elderly*, and both are discussed under the heading "special groups." It should be further noted that besides considering disabled women, the Program mentioned women as providers of care for disabled persons (paragraph 45). Although the Program notes that in some countries "as many as two thirds of disabled people are also elderly" (paragraph 47), no link is made between this statement and the fact that the sex ratio among the elderly is highly skewed towards females and that, therefore, discussion of disability is to a large extent discussion of *elderly disabled women.*

At the risk of over-simplification, one may say that the Plan of Action for Aging provides an appropriate conceptual framework for analyzing the process of aging, whereas the Nairobi Forward-looking Strategies for women and the Program of Action Concerning Disabled Persons identify some of the issues that women face once they are elderly. However, these latter two instruments give an inadequate basis for social planning for aging women.

The different approaches to aging and the elderly contained in these international planning instruments could lead to conflicting actions if governments followed their recommendations. The inadequacy of these plans in regard to aging women does not imply that the instruments themselves are useless; in fact, everyday experience demonstrates the contrary. At this stage, it could be useful to broaden ECOSOC's request to harmonize the plans through elaborating on relevant issues and ensuring their overall coherence and complementarity, at least in the area of aging women.

SOCIAL POLICY FOR AGING WOMEN

Planning for Future Aging Through a Cohort Approach

Once it is recognized that the aging of individuals and populations is a process, the value of discussing future scenarios and planning for the ones that are desirable becomes self-evident. With this in mind, it is of interest to examine the traditional period planning approach, based on planning for the elderly in a given year, e.g., 1990, 2000, 2025.[7] Then it will be possible to contrast the contributions that a different approach, based on cohorts, could produce.

The Period Approach and Some Related Issues

In illustrating how the period approach functions, one can start by examining the current situation of elderly women. Their situation is the result of their history. In Latin America, over 70% are now living in urban areas (a high percentage when compared to other developing countries), many having migrated to the cities in the 1950s and 1960s. According to the International Labor Organization (ILO) (1986), only a small proportion could be considered "active." These elderly women are to a great extent "dependent," particularly on their children, who tend to be numerous since past fertility was relatively high. What is important to note is that the period approach, by focusing on the results of past events, tends to emphasize welfare aspects: Elderly women are, in effect, seen as needing economic, health, and other forms of support. In all countries such needs involve costs; in developing economies, such costs are necessarily high in relation to resources.

The question then arises of how programs to meet these needs can be financed, and by whom. Since values change over time, younger generations might not feel that they should have to care for their elders or be willing to make sacrifices for them. Although economists often ignore the implications of changing values, social planners cannot do so. Intergenerational conflict can be created or increased, confronting governments with difficult choices. Typically, the choice is made in favor of younger age groups. Such conditions make it difficult for the elderly to participate effectively in decision-making, and also contribute to the erosion of their status: Others pay for them, so they are in a weak position to negotiate.

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[7] The period approach has many implications. For example, most pension systems are based on intergenerational transfers at a given date and therefore influenced by factors such as the age structure of the recipient and contributing populations.

With the period approach, the tendency is simply to project current needs of the elderly into the future to respond to the expected situation. Thus, planning can take place, for example, for the number of hospital beds or the acceptable level of pensions (for those women who might be entitled), based on present norms or expected levels of resources. In such cases the elderly of today need not be involved in the planning, and experience suggests that persons now in the 40–49 age group will be unlikely to take an interest in plans that will not affect them for 20 or 30 years. Social planning based on the period approach is thus largely a matter of responding to a predetermined future situation; it loses sight of the possibility of modifying the "future" through action today. A static approach tends to encourage considering the needs and problems of the elderly as a given, rather than seeing that people age gradually and therefore are able to plan for the future and take measures to prevent or postpone the occurrence of probable future difficulties.

Period analysis would tempt the social planner to ignore differences in histories and the influence of diversity within standard age groups. For example, women who will be in the age groups 60–74 in 1990 in Latin America were 20–34 years old in 1950; most were therefore brought up in rural areas, but eventually migrated to cities. They bore a relatively large number of children, have a rather low level of education, and typically do not benefit from social security. They do not provide a suitable model for planning for later generations who will reach the age range 60–74 in 2010. The latter were 20–34 in 1970, were mostly born and brought up in cities, have a much lower fertility level, a higher education level, and have been more economically "active" (i.e., salaried). The contrast between these two age cohorts is such that their situation and needs in old age could be very different.

Furthermore, there are also conceptual difficulties with the period approach. Surveys often show elderly women never having had an occupation, since such information about their past is usually not collected. Therefore, the characteristics of the elderly are often poorly documented. In such a context, variations among countries, within countries, and over time are given minimal attention, although one of the important tasks of social planning is to take into account such diversity.

The Cohort Approach to Social Planning

The cohort approach can make a significant contribution to social planning since it opens the possibility of a dialogue between the planners and decision-makers on one side and those concerned with the results on the other, as can be illustrated by an analysis of the information found in tables 2, 3, and 4.

Table 2. Estimated and projected life expectancy for women in Latin America at ages 45, 60, and 75 for various years.

Age	1975	1985	2000	2025
45	29.8	31.6	32.9	34.8
60	18.0	19.3	20.2	21.6
75	9.0	9.7	10.2	11.0

Source: United Nations, 1982 (rounded to one decimal place).

Table 3. Estimated and projected numbers (in thousands) of women in Latin America aged 45, 60, and 75 for various years.

Age	1975	1985	2000	2025
45	1,362	1,710	2,904	4,922
60	803	1,061	1,535	3,533
75	330	466	740	1,650

Source: United Nations, 1982.

Table 4. Estimated "capital" (in millions of years) of women in Latin America at ages 45, 60, and 75 for various years.[a]

Age	1975	1985	2000	2025
45	40.6	54.1	95.5	171.4
60	14.4	20.4	31.0	76.4
75	3.0	4.5	7.5	18.2

[a] Capital years = (life expectancy at age x) times (estimated number of women at age x).

In 1985, the life expectancy of Latin American women at 60 years of age (those between age 60 and 61) was estimated to be 19 years (United Nations, 1982).[8] There were just over one million women of that age, representing a human "capital" of 20 million years. Similar calculations can be made for all women above a certain age, and it can be easily seen that the total "capital" is enormous. It can also be seen that the simultaneous increase in the number of elderly and of their life expectancy leads to a rapid increase in this "capital" of years: 60-year-olds in 2025 could represent a "capital" of over 76 million years.

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[8] This could be an underestimate since it represents recent mortality conditions.

ILO estimates show that economic activity rates for females in Latin America are low (United Nations, 1988). Moreover, they are projected to decrease rapidly in the future, which would transform these women into dependents.[9] The immediate question this raises is how developing countries (or developed countries for that matter) can afford to pay for such a large and increasing number of dependents. Economic difficulties would lead to arbitration between human rights and economic "realities."

However, the cohort approach in social planning can change the perspective of the debate. Being elderly is often perceived as a break in the life cycle; but it is an artificial break created by the society at large in what should generally be a continuing process. Therefore the choice of the term "capital" is deliberate in order to highlight the potential resources the elderly represent. The question then becomes how one can best use the "capital" of years to benefit aging women and the rest of society, rather than wasting it to everyone's detriment.

It is possible to extend this idea. Studies show that aging women tend to suffer more from disability than men, and the concept of "life expectancy free of disability" has been developed, for example in Colvez, 1986. (This indicator is calculated in a manner similar to the normal life expectancy and can be used in combination with it.) It introduces a qualitative element that is important for social planning. A study in France shows that for women aged 60 in 1982, nearly 60% of their remaining life expectancy would be without disability, whereas at age 75 the figure falls to 40%. If, for discussion purposes, the same rate were to be applied to Latin American women, in 1985, 8.2 million years of their "capital" in years would be spent in disability; but over 12 million years would be free of disability.[10] Taking into account the tremendous cost of disability to the individual, the family, and society, it can be seen immediately that any improvement in the life expectancy free of disability of aging women could be of tremendous benefit to all concerned (including to younger women in the family, who in the past have mostly carried the burden of caring for disabled elders). Any reduction in disability rates would contribute to improving the public image of the elderly as active citizens rather than as a burden. Furthermore, the indirect benefits of preventive measures in this area would be significant, since the burden of caring for invalid older men is generally borne by their aging spouses, whereas invalid aging women are typically looked after by female relatives or are placed in institutions (if available or within reach financially). According to some studies in the United States (Doty, 1987), elderly female spouses (average age of 69) constituted 23% of all care-givers to the disabled elderly living in the community.[11] It was also noted that the emotional stress involved in giving care was very high for these women.

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[9] This does not mean that the women would do "nothing," but that they would do little salaried or recognized work (see Russell, n.d.). It can be assumed, however, that future cohorts of elderly women will have expectations that may be difficult to reconcile with the implicit values behind such projected activity rates.

[10] Warnes (1987) underlines the fact that elderly people contribute more than is realized and that they are more independent than dependent. However, their contributions, just like those of women, generally suffer from a great degree of invisibility and lack of social recognition.

Another aspect of life expectancy free of disability is the type of disability to which women are particularly prone. For example, in Indonesia, a WHO-sponsored survey found that the most frequent functional disability related to age involved fetching water, typically a "women's job" (Doty, 1987). Such knowledge would help the social planner to focus attention and effort on appropriate preventive measures, such as alleviating domestic chores through the provision of piped water. The return on such investments could be significant, by way of lower disability rates among elderly women. Developing countries could improve the situation of the disabled as a result of general modernization.

The cohort approach introduces another new dimension to social planning through calculation of probabilities of events in the life cycle of a specific cohort. Just as the risk of disability can be introduced into the concept of life expectancy, the probability of occurrence of other events, such as widowhood or specific health risks, can also be introduced. This means that social planners can attempt to evaluate the impact of changes in terms of probabilities, projected frequency, distribution, or likely timing. The usual method of making these projections is through the preparation of multiple-decrement tables.[12] For example, improvements in housing conditions can reduce the impact of disability: housing should not be designed for healthy young adults only, leading to the need for expensive adaptations at a later stage or forcing the occupants to move out when they face difficulties. The probability of disability should be taken into account in calculations and in design. This cohort approach has the added advantage of making it easier to estimate the cost of different factors. For example, planning on the basis of an assumption of declining activity rates might not be a desirable objective once the full impact of this total dependence is estimated.

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[11] The use of examples from developed countries in the area of disability of the elderly appears reasonable for the case of Latin America, since WHO has found that there exist similarities in this area.

[12] A life-table is a table in which there is only one decrement (deaths); in a multiple-decrement table, several decrements can be introduced (such as death, widowhood, retirement).

As was mentioned above, perhaps one of the most important aspects of the cohort approach is that it facilitates the participation of the interested cohorts and makes such participation more meaningful. To continue using the disability example, a dialogue between the social planner and the aging cohorts on housing conditions can be generated. To be effective, this dialogue should take place not with the cohorts who are already elderly and disabled, but with women in the 20+ years age groups, since it is the younger cohorts who will ultimately benefit from current measures but who will also have to pay for design based on future, as opposed to present, needs. Such a dialogue implies that each cohort is informed of the facts and therefore is in a position to make responsible choices between immediate and longer term advantages. Even when it is not possible to evaluate precisely the probabilities of various events happening to cohorts, such considerations are useful in any decision-making process for identifying alternative policies.

Combining Period and Cohort Approaches to Social Planning

It would be neither possible nor desirable to give up the period approach, which provides certain perspectives useful to the social planner. Moreover, the cohort approach does not always bring immediate returns. It can only be brought to bear gradually, just as the results of reforms in education introduced in certain grades only materialize many years later.

The cohort approach places the emphasis on prevention and on measures to modify future conditions that are suggested by projections of undesirable results. Indeed, in this approach, the most appropriate age group for planning purposes can vary according to the issue: mid-life (45–59) might be an appropriate age to consider issues of "retirement," change of activity, and forms of economic support; teenagers should be the focus of programs dealing with consumption of alcohol or smoking;[13] the elderly themselves would be targeted in efforts to increase mobility and autonomy inside the home and in the community.

The age group of women at midlife is particularly strategic for many issues concerning aging: it is decreasingly involved in child-raising, often has duties towards aging parents, is becoming sensitive to aging, and still has sufficient years ahead for long-term planning. The question is not only how to tap this potential, but also how this group can become aware of the issues and organize itself to interact with social planners in order to have a say in future policies and programs of concern and to ensure its own participation in present and future action.

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[13] Stanley (1987) notes the impending epidemic of tobacco-related diseases in developing countries and that cancer of the lung might become the "most common cancer in women worldwide in 20–30 years, unless effective action is taken."

Aging is a continuing process and therefore requires planning methods adapted to it. In view of the increasing life expectancy of women, their aging deserves much more attention, particularly if the advancement of women is to bring a lasting improvement in the quality of their lives. The risk of younger women promoting causes that might be prejudicial to their own interests at an older age is a real one, and it should be remembered that a meaningful life should be meaningful to its end and not just to an arbitrary cut-off date. Furthermore, no society should be considered "developed" if it wastes a major portion of its human resources simply for lack of imagination. All concerned need to participate in meeting the challenge of ensuring a meaningful life for aging women.

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PROFILE OF THE MEXICAN ELDERLY WOMAN: A COMPARATIVE STUDY

Raquel Bialik[1]

MATERIALS AND METHODS

In 1985, 6.15% of Mexico's population was over 60 years of age; elderly women accounted for 3.27%, and this proportion is increasing. Our research[2] studied 770 elderly women of different backgrounds and in three different environments in Mexico: urban (Mexico City, City of Puebla, Cuernavaca, and Jalapa in Veracruz), rural (rural towns in the states of Morelos and Veracruz), and indigenous (Nahuatl, Otomi, and Totonac Indians). The Indians were interviewed by bilingual personnel from the National Institute for the Indian Population (INI). The study subjects included women interviewed at home, as well as persons who had gathered at social centers or were living in old-age homes.

The study population can be divided into subgroups by age, as shown in Table 1.

RESULTS

General Background

The illiteracy rate was high among our sample, with 40% of the total sample and 87% of the indigenous subgroup illiterate. As expected, the highest education levels were found among the urban elderly, with 3% of these women having had a preparatory school or university level education.

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[2] Cofinanced by the PIEM (Women's Studies) of El Colegio de México and by the General Office of Scientific Research of the SEP under grant C87-01-0143.

Table 1. Age-group distribution of 770 elderly Mexican women included in this study.

Age	Overall	Urban group	Rural group	Indian group
60–64 years	35%	38%	27%	44%
65–69 years	21%	16%	25%	21%
70–79 years	29%	28%	35%	25%
80 years and over	15%	18%	13%	10%

Fifty-nine percent of the study subjects were born in small provincial towns.

The most common marital status was widow (44%); 34% were married, 9% were single, 6% had been abandoned, 5% were in a consensual union, and 2% were divorced. The single and abandoned categories were much more common among women in the urban setting than in the other two groups.

In economic terms, 60% of the sample belonged to the middle class and the remaining 40% could be classified as lower class. This does not mean that there are no high-income elderly women, just that they were randomly excluded from this study. A third of the sample had no source of personal income at all, and another 12% had less than $5 per month. The large majority (81%) received no pension, and over half of those who did receive one got less than $20 per month. The highest income levels were found among the urban group. The women in the sample were supported by their children (36%), husband (26%), government agencies (8%), and other family members (5%), and 18% supported themselves.

Most (86%) had had children, and for 39%, all their children were still living. Family size was found to be largest among the indigenous group. Those who did not have any children were found mainly among the sample of women institutionalized in old-age homes (40% of the institutionalized elderly women also did not have any siblings). This indicator could be an important predictor of future living conditions of the elderly.

Overall, the study subjects most frequently lived with their children (34% of the total, 40% among the rural population, and 25% among the urban). The largest proportion of the indigenous women (44%) lived with their husbands. Twenty-three percent of the urban group, versus 7% of the rural and none of the indigenous group, lived in institutions. Thirteen percent of the total population and similar percentages within each group lived alone. Among those women who gather at social centers, the percentage is much higher—27%.

About a third of the women saw members of their family daily; the percentage was highest among the Indian group (43%). About 20% saw their families occasionally, and 11% saw them only yearly (highest among the rural group). The institutionalized population saw family members the least overall, usually once a month.

Work Status and Income Distribution

At the time of the interview 44% answered that they worked (among the Indians, 63%). This large proportion reflects the attitude that domestic work and other chores are still considered "work" even though no pay is received. Types of work reported were, in decreasing order of frequency, domestic work, manual labor, agricultural (22% among the rural and indigenous groups), and paid employment outside the home (10% among the urban group). Sixteen percent reported that they had never worked, and of those who said they had worked at some time in their lives, 55% said they had worked prior to age 20.

Patterns of spending differed among the groups. The Indians spent most of their money on food; the urban group spent six times as much of their money on "personal expenses" as the indigenous group did. Expenditures on housing were highest among the urban group, while the rural group spent more than the others on health services and for recreation. Very little was spent on dress and education by any group, although such expenditures were higher among urban women.

Most women (60%) in the overall sample have no savings at all. Savings were highest among the rural population. Reasons given for saving were for personal expenses, for "the future," in case of sickness (highest prevalence of this answer among the Indians), and in order to feel more secure.

Health

The largest proportion (37%) felt that their overall health was "relatively good," while 29% said it was good, and 33% not good. The health problems most frequently mentioned were osteoarthritis (22%), digestive disorders (13%), heart problems (8%—most frequent among the urban group and least reported by the Indian group), pulmonary problems (their prevalence among the groups being the reverse of that of heart problems), and diabetes (most frequent among the rural group—8.7%). Only 1% of the total mentioned mental illness as a problem. It should be remembered that these responses measure only perceived illness, not necessarily diagnosed or treated maladies.

Asked when the condition began, 20% answered that it was a recent affliction, 18% said it had lasted five years, 9% said it had been with them more than 30 years, and 2% said it was lifelong. Regarding care for health problems, 42% said that a doctor provided care (highest among the rural group), 25% said they received care in institutions (mainly among the urban group), 9% depended on themselves and their family (mostly within the indigenous group), and small percentages said they used paramedics, "others" (traditional and folk healers), or friends.

On smoking and drinking habits, 10% of the total sample smoked and 30% drank alcohol. Drinking was more common among the indigenous group, 8% of whom said they drank daily. Members of the urban and rural groups specified that they drank in social gatherings.

Social Life

When the unmarried women were asked if they had a close male friend, 16% of the total said they did, with rates being highest among the urban group and particularly among divorced women and the young elderly (60–69 years old). Many met their friend as a neighbor. Twelve percent said that their contact consisted of talking together, usually every two weeks, but daily for 6.5%. A very small percentage (0.9%) said their relationship included sex, and this proportion was highest among the rural group, as was the proportion of those who said they "go out together."

The majority of the total sample (87%) said they felt at ease with people, mainly because they could and did interact and socialize with others. Many of those who said they did not feel comfortable with people were from the oldest age group.

Ninety-two percent practiced a religion (89% were Catholics; protestants were somewhat more common among the rural group). Those in the age group 70–79 were the least religious. Religion was usually practiced once a week, but the oldest were more likely to participate in religious ceremonies daily, while the indigenous women mostly participated only during religious festivities. The study subjects said they got peace of mind, hope, resignation, and strength from their religious beliefs.

Most of the subjects were apolitical, with only 11% having a political affiliation and few voting.

Recreation consisted mainly of handiwork (weaving). Some traveled twice a year within Mexico (10% traveled alone), mainly by bus. One percent participated in some sport.

Most (70%) had plants in their homes, and 55% kept domestic animals, especially birds. Pets were kept because they allowed the elderly to give and receive affection.

Sexual Activity

In our study, 12.2% of the total sample still had sexual intercourse, and no significant differences were found between the urban, rural, and indigenous groups. Sexual activity was much more frequent among the married women (as opposed to men, among whom marital status is not predictive of sexual activity) and in the 65-69 years age group. The frequency of sexual intercourse varied from monthly (basic pattern in the urban group), to every two weeks (among the rural group and divorced women), to weekly (especially in the Indian group). Two percent of the "young old" reported daily sexual contact, but only 0.3% of the whole sample.

For many of the sexually active women, their husband was their only sexual partner. Having more than one partner was more frequent among the indigenous group, the age group 65-69 years, and divorced women. When asked if they discussed sex with anyone, 33% said they talked to their female friends, and 2% of the Indian group said they talked to their priests.

When asked if they found pleasure in sexual intercourse, 11% said they did (22% of those 65-69 years old). The reasons given were that they felt comfortable with sex, it was something natural, and it brought closeness (a chief reason given by married women). Those who did not find sex pleasurable said the reasons were marital problems, feeling used, experiencing pain, or feeling guilt (especially among the rural group).

Those who no longer had sexual intercourse had stopped 10-20 years ago (20%); 30-50 years ago (10%, especially among the group 80 years and over); five years ago (9%, more frequent among the divorced women); one year ago (3%); or they had never been sexually active (2% overall, but the answer given by 26% of the unmarried women). The urban population and the "young old" had most recently stopped their sexual activity. Reasons for stopping or interrupting sexual activity were death of spouse (30.5%), illness, separation, age (7%, more common among the Indian women and age group 70-79), marital problems, and being alone.

Of the total sample, 3.5% answered that they masturbated (10.7% among the unmarried women, and most frequent in the 65-69 years age group). Reasons for not masturbating were not needing to (22.5%) or feeling it was immoral (8.2%). Reasons for masturbating were because it made them feel better (2% overall, but a much more frequent answer among unmarried women and in the rural population) and because they wanted or needed to (the answer given by 22% of the divorced women).

Self-perception of Problems

Half of the total sample mentioned having problems, with slightly higher percentages among Indian women, abandoned women, and women with children. The types of problems named were family problems, poor health (13% overall, and highest among Indians and the age group 70 and over), economic problems (8%, especially in the 70-79 years age group), emotional problems (6%, most common among women 60-64, the unmarried, and childless women), and social problems (1%, most frequent in the oldest women). Regarding how these problems could be solved, the most common answer was "sólo Dios sabe" (only God knows). Other, less fatalistic answers were that understanding or a higher income could resolve the problems; however, 8% answered that their problems had no solution.

Self-esteem

More than half (55%) said that there was something about themselves that they did not like. Attributes mentioned were poor health (22%); a weak personality (a more common answer among urban and unmarried women); an agressive character (commonly mentioned by divorced and rural women); their age (a more common answer among the 70-79 age group and the divorced); poverty (4% overall, and higher among abandoned women and the 70-79 age group); and physical appearance (mentioned by those younger than 65).

When asked if they were happy, 56% said they were (highest rates among the rural group and unmarried women); 34% said they were relatively happy, and only 7% answered that they were unhappy—predominately those in the urban group and among the oldest old. As a group, widows were slightly more likely to say they were unhappy.

The reasons given for happiness included family, good health, and lack of problems. Reasons for unhappiness were economic problems (9%) and loneliness (6%, highest among the 70-79 age group). Over half (53% overall, and higher among the divorced group and those 70-79) said they lack something, such as health, money, family, support, activity, and privacy. Lack of health was cited by 18%, most frequently among the indigenous group and the oldest old. Nine percent of the sample said they had everything they needed (highest proportion in the urban group).

When asked whether they felt useful, 73% said they did (especially rural women, married women, and those with children), and the reasons given were because they worked around the house (43%), because they were self-sufficient (15%, highest among the urban and divorced groups), because they worked (12%), and because they helped others (highest among the rural group and those aged 65-69). Eleven percent said they did not feel useful. The feeling was most common among Indian women, abandoned women, and unmarried women, and increased with increasing age. Feelings of uselessness were blamed on disability, lack of their own income, and apathy.

Concept of Their Condition as Elderly Women

The study participants were asked to define what an elderly person ("un anciano") is. Most said it was an experienced aged person and someone deserving of love and respect. Other, less frequently mentioned characteristics were physical impairments (mentioned by the 70-79 years group), inactivity and disability, and someone useless and rejected. When asked if they considered themselves "ancianas," 40% said no (highest rates among the urban and divorced groups), and 35% said they did. This answer was much more frequent among the Indian group, at 47%, and among widows, which corroborates the thesis of Morgan and Jackson (1980) that different groups perceive their aging differently. The remaining 25% answered that they sometimes felt old; this answer was more common among women who had children and those in the 60-64 years age group. The chief reason given for feeling old was simply age (37%). Interestingly, this answer was much more frequent among Indians (58%), even though they represented the youngest of the three subgroups. Other reasons were physical complaints, especially among rural women and the 70-79 age group. Those who did not feel old said it was because they felt useful, self-sufficient (both answers given by the "young old," urban, and divorced groups), and had good health.

The subjects were asked to grade the various stages of their lives from zero, for the time period when their lives were going most poorly, to 10, for the time of highest achievements and greatest happiness, and to give reasons for their scores. Thirty-five percent gave childhood the highest grade, most frequently those in the urban environment and divorced women. The reasons given were having had good parents and having received love. But 6.5% graded childhood as zero (a somewhat higher percentage among the rural group and those aged 70–79), due to economic problems, family problems, and loneliness, or because they did not feel they had had a childhood (an answer common among the Indian women). As for adolescence, 33% scored it the highest, mainly because of family (indigenous women), overall happiness (unmarried women), and friends. Those who scored it lowest did so because of economic problems, "bad character," loneliness, and problems in school.

Adulthood was graded highest by 34% of the women, who said it was a happy time because of their husband (27%, more frequent among the rural population) and children (12%, higher among the indigenous group). Only 2% graded adulthood very poorly, and the reasons given were economic problems, sickness, death, and separation; however, 14% of divorced and abandoned women gave this answer.

As for their present life stage, 32% of the sample graded it highest, and 2% graded it lowest (more prevalent among the urban group). Reasons for a high rating were the presence of support amd company (28%), and happiness, usefulness, and good health. The low ratings were due to sickness (13.5%, most prevalent among the rural and indigenous groups, the eldest, and widows), suffering (4%), and loneliness (3% overall, but 10% among unmarried and childless women).

Expectations

Twenty-three percent said that their life at present was good. Only 4% said it was not good, and 3% specified that loneliness was the reason. More than half were fatalistic about the future, saying it held for them "whatever the Lord decided." Other attitudes were that their future would continue to be much like the present, that they would be self-sufficient, and that they expected death.

When asked what they expected from their closest relations, they said that from their partner they expected company, a continuing relationship, or nothing (8%). Of their daughters, most expected love and attention, but 7% did not expect anything. Of male friends, 17% expected friendship, 17% expected nothing, others expected understanding and help, and 26% said they did not have any male friends. The clergyman was expected to give, first, understanding (25%), absolution, strength, and instruction. Of neighbors, many simply expected to maintain a trouble-free relationship; others said they wanted friendship (28%), help, or nothing (21%).

Acceptance of Change

Twenty-eight percent of the study sample responded that they accept innovations easily; 17% said they sometimes did, 21% said it depended on the type of change, and 20% said they did not accept change easily. The types of innovations accepted were ideas (19%), technical innovations (12%), dress (10%), music (5%), and written materials (1%). Reasons for rejecting change were conflict with religious beliefs and insecurity.

CONCLUSIONS

In this study we closely examined a sample of 770 women 60 years of age and older in an effort to take a look at the aging process through their eyes. It is clear from our study that elderly women do not make up a homogeneous group.

Our data indicate that women 65-69 and those over 80 more fully accept their lives and function more completely, especially the 65-69 group, which maintains a fuller sexual, social, and emotional life and seems to be the most optimistic and happiest. The most fatalistic and negative group, and the one in which self-esteem is lowest and economic problems and loneliness are greatest, is made up of women we refer to as "in transition," those 70-79 years old. The 60-64 years old group is also in transition in a different way, by being on the threshold of the group defined as elderly, and we believe that their problems stem from the social imposition of "old age," which they have trouble accepting and take time adjusting to.

The rural group reported both more health and more marital problems. The Indian group included more women who perceived themselves as elderly, even though it was chronologically the youngest. Women who were divorced were more likely to socialize and to do so more frequently. In general, unmarried women showed fewer problems in old age, but reported more feelings of loneliness during their adult life.

We conclude from this study that self-perception and attitudes about old age are directly related to whether or not an individual feels useful (not *is* useful, but *feels* useful). In general, our sample responded that they were happy. After family life, religion also played an important role.

In order to gain a fuller understanding of aging, a similar study needs to be undertaken of the elderly male population, in order to compare the results. It would then be possible to confirm or refute the conclusion of Bengtson *et al.* that women are better adapted to and therefore happier in this final stage of life than are men.

Our sample included representatives of four risk groups for social disadvantage, based on age (old people), sex (women), social class (low and marginal groups), and ethnicity (ethnic minorities, such as our Indian sample)—those at "quadruple jeopardy," according to Markides (1980). We found, however, that at least in self-perception and in their milieu, these persons did not score the lowest with respect to their mental and physical well-being or their functional level. Could this mean that old age is truly a social leveler?

At the end of the questionnaire, we asked for the subjects' reactions to and commentaries on the survey. In general, the responses were favorable, saying that it was a very good questionnaire (28%), that it was useful for getting to know older women (14%), and that is was also useful for getting to know oneself (11%). The less favorable comments were that it was too long (10%), indiscreet (7%),[3] and that it was of questionable utility (11%, an answer especially common among the Indian sample).

We believe that the best ways to help solve, or at least diminish, the problems that old age causes are to change attitudes and to study aging with a scientific and applied approach. Mexico, like so many other countries in Latin America and the rest of the world, suffers from a lack of continuity between policy makers and researchers. What one group does has little effect on the other's actions, so that programs are usually implemented without the benefit of solid data or without regard to the results of previous research. First-hand data that are gathered scientifically, although they may be discussed and published, usually find little application. The result is programs that have a political reason to exist, but that solve little or are inadequate in scope.

Our study has served to make the elderly who were interviewed explicitly aware of the details of their lives, needs, and expectations. With facts and first-hand data, myths about aging can and must be dispelled. The problem is that these myths cut across social and cultural boundaries and become incorporated into one's being. Thus, the process of demythification must begin early in childhood, when little girls are being taught what to expect as adults and how to behave and function "properly" then and later. Further, this information must be spread to policy-making circles so that it becomes useful for making aging better understood by our society and helping to assure that the aged are better cared for.

Aging is a dynamic and heterogenous process. Program planners should take this into consideration and ought never to forget the uniqueness of each individual, especially in the final stage of life.

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[3] It should be noted that more problems were experienced convincing institutions to help us gather data on sexual activity than in questioning the respondents about their sexual lives and thoughts. However, the question on number of sexual partners was mentioned by 7% of the women as "aggressive and indiscreet."

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SOCIAL LIFE AMONG FEMALES AGED 75 AND OVER IN BARBADOS

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INTRODUCTION

The aging of the population has been a major demographic trend in Barbados for the past 100 years. For example, census data show that since 1881 the proportion of persons aged 65 years and over has dramatically increased, moving from 5% in 1881, to 7% in 1911, to 8.8% in 1946, and to 10.5% in 1980; projections for the year 2000 are an increase to 15%.

Some interesting observations emerge from the comparison of these data with regional and worldwide estimates. For example, in 1980 Barbados had one of the highest proportions of persons aged 65 and over (10.5%) in the commonwealth Caribbean, except for Montserrat (13.0%) and Dominica (10.9%). In fact, the old-age population in Barbados resembles more that of an urban industrial society (estimated at 11.4% in 1980) than that of the Caribbean (estimated at 6.2% in 1980) or that of its Third World counterparts (estimated at 3.9% in 1980) (Binstock *et al.*, 1982).

Three main factors can help explain these trends: declining mortality rates (hence increased life expectancy), declining fertility rates, and extensive migration out of the country in the 1950s and 1960s. Data from the *Report on Vital Statistics and Registration in Barbados for the Year 1940 and 1980* show that between 1940 and 1950, death rates in Barbados declined from 26.7 per thousand to 8.6 per thousand, and that fertility rates declined from 29.2 per thousand in 1940 to 16.4 per thousand in 1980. For the period between 1921 to 1965, life expectancy patterns rose from 28.5 years for males and 32.9 years for females to 65.5 years for males and 70.9

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years for females (Massiah, 1981). Finally, available statistics on migration indicate that between 1951 and 1970 there was a net loss by way of migration of 32,600 persons (Ebanks, 1975), most of them young, from a population which was 193,680 in 1946, and 236,891 in 1970. Clearly, this combination of declining mortality, increasing life expectancy, declining fertility, and heavy outward migration of the younger population has contributed to the increase in the proportion of old people in the overall population.

Further analysis of the 1980 census statistics shows that among the elderly, there were more women (60.3%) than men (39.7%), more were married (44.0%) than single (27.3%) or widowed (26.3%), and more had only acquired primary level education (88.4%) than those who had finished secondary school (8.5%). Data from the 1970 census also showed that the elderly were more likely to live in one- or two-person households (61.7%) than in larger households.

A comparison of the elderly with the general population showed:

- that the elderly are more likely than the total population to be in the lowest educational category (88.4% and 63.1%, respectively), and the elderly are five times less likely to have acquired a secondary education;
- that the elderly are more likely than the general population to be married (44% compared to 30.9%), and five times more likely to be widowed (26.3% compared to 5.3%);
- that the disparities between males and females among the elderly are far greater than within the general population (5.2% compared to 2.6%); and
- that compared to the general population the elderly are more likely to be living in small households.

The above data and patterns suggest that the elderly constitute a population group in need of urgent social investigation; yet, except for population censuses which provide abundant but scattered data, the state of gerontological research in the Caribbean is essentially piecemeal and demographic in nature, and remains relatively underdeveloped. My own research in Barbados has attempted to go beyond the demographic approach by looking comprehensively at the elderly's social, economic, social, and psychological circumstances.

This research has demonstrated that one way to get some deeper insight into the social life among the elderly is to continue to investigate subsamples of their population. The subgroup chosen for analysis in this paper is the one consisting of females aged 75 and over.

This group was the obvious choice for research, given that available demographic data from the *Analysis and Census Data for the Seventeen Commonwealth Caribbean Countries*, p. 39, show that increased life expectancy will lead to an increase in the proportions of old old people; furthermore, demographic evidence clearly shows that life expectancy is greater among women than among men, making the proportion of old old women consistently greater than the proportion of old old men (Brathwaite, 1987; Brathwaite, 1988). In addition, even though evidence from a larger Barbados study suggests that elderly males are more likely than their female counterparts to suffer adaptation and dislocation problems, the general sociology of gender differentiation (Clarke and Lawson, 1985) does suggest that elderly females are more likely to be disadvantaged than elderly males.

This paper on the social life of females aged 75 and over has three main objectives:

- To present a social, economic, and psychological profile of this group in Barbados, with reference to their economic conditions, social relationships, health conditions, retirement, employment, and their attitudes toward death and dying.
- To show how this group compares with the total elderly population regarding the above indicators.
- To explore the policy implications of the above findings.

METHODOLOGY

The 75 respondents in this study constitute a subsample from a larger national random sample of 414 persons aged 65 and over which was conducted in 1982. Table 1 presents the major demographic characteristics of this subsample and how these compare with those of the total elderly population. These characteristics indicate that old old females primarily are engaged in unskilled manual labor (52.0%) or are unemployed (25.4%); are in the 75–84 age group (84.0%); are widowed (41.5%); have only a primary level education (89.3%); are heads of households (61.3%); and do not live alone.

THE FINDINGS

Regarding economic conditions, it must be emphasized that the level of economic well being among the respondents tended to vary according to

Table 1. Demographic profile of old old females compared with that of the total elderly population.

Characteristics	Old old females $N = 75$	Total old population $N = 414$
Occupational class		
White collar	10.7	8.0
Skilled manual labor	12.0	18.1
Unskilled manual labor	52.0	58.9
Unemployed	25.4	15.0
Age		
65–74	—	66.2
75–85	84.0	27.5
85+	16.0	6.2
Marital status		
Legally married	22.7	38.2
Common law	1.3	4.6
Single	32.0	20.5
Widowed	41.3	29.2
Other	2.6	7.5
Education		
Primary	89.3	92.6
Postprimary	10.7	7.4
Head of household		
Yes	61.3	74.4
No	38.7	25.6
Living status		
Living alone	33.3	26.8
Living with others	66.7	73.2

the indicator being used. For example, less than half (42.7%) expressed satisfaction with their economic conditions. In looking at income levels, well over three quarters of the respondents (86.7%) indicated receiving a weekly income of $50.00 or less per week, even when old age pensions were a minimum of $30.00 per week. Furthermore, at this time only 25.5% of all Barbadian households received less than $50.00 per week, showing that old old females were at least three times more likely than the general population and 11.6% more likely than the elderly populations to fall within the low income group. On another point, the main sources of income were pensions, with 70.8% indicating they received such pensions. Only one third (36.1%) indicated getting financial support from relatives, and even smaller percentages indicated getting income from personal earnings (18.6%), friends (13.9%), and other sources (15.5%).

These observations make interesting reading because it is generally assumed that the deprivations of old age may be offset by the support of family and friends, especially in Third-World settings which have more integrated social network systems. Not only do the data show unexpectedly small percentages that receive financial support from those sources, they also show that when they do get income support from these sources they receive only small amounts and very infrequently. This income inadequacy is complicated by the fact that respondents tended to report weekly expenditure in excess of weekly income. For example, while 86.6% reported getting $50.00 or less per week, just over half (51.8%) reported weekly expenditures in excess of $50.00 per week mainly for food and fuel.

Regarding food and nutrition, data show some subjective satisfaction among the respondents—nearly two thirds (66.2%) described their food situation as without problems. At an objective level more than three quarters (78.1%) indicated taking two or more meals in the 24 hours preceding the interview.

There needs to be some caution, however, in interpreting the food and nutritional circumstances of this group: even though they are only a minority, as many as 33.8% defined their food situation as problematic, and just over one fifth (21.9%) consumed fewer than two meals in the 24 hours preceding the interview.

Even more interesting is the fact that one tenth (11.1%) and one fifth (20%) of the subsample, respectively, went without breakfast and dinner in the 24-hour period preceding the interview. Furthermore, when the food count method (a crude method of assessing nutrient contents) was used, it turned out that the meals consumed were essentially energy rich, and often deficient in protective and protein rich foods. For example, 42.6%, 16.4%, and 50.0% had breakfast, lunch, or dinner, respectively, which were low in protein rich foods; 69.4%, 51.5%, and 80%, respectively, reported having breakfast, lunch, and dinner with a low protective food content.

The picture regarding housing was much more favorable, in that 82.3% expressed satisfaction with housing conditions, 88.6% owned their houses, 91.9% had a piped water supply, nearly half (49.3%) had flushing toilets, just under two thirds (60.8%) used gas or electricity for cooking, and two thirds (66.7%) used electricity for lighting. These data show that old old females compare favorably with the general population with respect to house ownership (88.6% vs. 70.2%), piped water supply

(91.9% vs. 70.2%), and flushing toilets (49.3% vs. 43.6%), but they compare less favorably with respect to fuel sources (60.8% vs. 67.8% for cooking, and 66.7% vs. 83.0% for lighting). Further data on household facilities show that 38.4% had access to a motor car, 65.5% to a refrigerator, 52.7% to a telephone, and 68.9% to a radio, which, with the exception of access to a motor car, places them at a disadvantage with the total population, for whom the comparable figures are 79.2%, 54.7%, and 81.6%.

There is another side to the housing picture, however, and it shows that about one tenth (11.4%) did not own their home, 8.1% had no piped water supply, half (50.7%) had no flushing toilet facilities, 39.7% used cooking facilities other than gas or electric, and about one third (32.4%) had no access to a motor car. Just over one third (36.5%) had no access to a refrigerator, 46.7% no access to a telephone, and 31.1% no access to a radio.

In terms of social and psychological characteristics of old old females, the data show crime (36.2%), lack of social care (23.4%), and the cost of living (21.2%) as the group's main concerns. It is interesting to note that these differ markedly from overall national concerns in 1982, the year in which the survey was conducted, where unemployment (42.5%) and the cost of living (35.7%) were the main concerns, and very few (3.7%) expressed concern about crime. There is also evidence that the labeling and stereotyping of old old females is fairly prevalent, with the labels old (71.2%) and old girl (35.2%) being most frequently used to refer to them.

Nonetheless, it is noteworthy that, except for the label "gramps," which about one-fifth (19.4%) of those so called objected to, stereotyping and labeling of the group did not seem to be a major source of concern to them. With respect to a self-concept of old age, only a minute 5% of old old females expressed embarrassment about their old age.

In addition to fears and concerns the old old said there were several things that pleased them about life in Barbados. Small percentages indicated they appreciated the religious nature of the country (12.7%), the improvement in the standard of living (11.1%), and the country's freedom (11.1%); 14.3% said nothing.

The respondents in this study also had a tendency to perceive their situation in society in unfavorable terms. For example, more than two thirds (68.7%) felt that the general public was unfavorably disposed towards them, over half (53.0%) expressed dissatisfaction with the treatment they were given in society, 82.8% felt that young people were being treated better than they were, while just under half (44.6%) felt that things had gotten better for them over the years. Significantly, a third (31.1%) felt that things had gotten worse. There was also a strong feeling of underachievement within this group—just under half (46.4%) said they did not achieve the things they wanted to.

Further analysis of this data on the social and psychological characteristics of the respondents show that they looked more to the present (53.8%) and future (27.7%) than to the past, and that God (47.7%) was a major focus for them.

Turning to social relationships, the findings suggest that most old old females lived in multiperson households (68.5%), had children alive (61.6%), had contact with them (70.6%), indicated getting help from them (86.4%), had grandchildren with whom they had contact (69.5%), and had good relations with their spouses (38.5%). Over three quarters (75.7%) had living siblings, about two thirds (69.8%) of these said that they had no contact with them, and nearly two thirds (64.2%) said that they had good relations with them. With reference to friendship, most (90.7%) said they had good friends, and of these three quarters (74.3%) said that they had good relations with them. Finally, 80.6% said they had good relations with their neighbors, and 44.4% of these said that they rely on them for help.

In terms of social activities the vast majority (93.2%) indicated having leisure time activities, mainly listening to radio (63.9%), church going (59.7%), reading, and watching T.V. (33.3% each).

The above discussion might suggest that old old females are socially integrated, but social isolation should not be dismissed, at least for some of the respondents. First, the existence of these social networks does not tell us much about the quality of the relationships within them. Furthermore, an alternative reading of the evidence shows that about one third (31.5%) lived alone, much higher than expected in supposedly close-knit societies, and that well over a third (38.9%) indicated experiencing loneliness. A similar proportion (38.4%) had no living children, one quarter (29.4%) of those with living children said they had no personal contact with them, over a tenth (13.6%) got no help from their children, a third (30.5%) had no contact with their grandchildren, and two thirds (61.5%) had poor relations with their spouses. Just under a third (30.2%) had no contact with their siblings, and of those who did, just over a third (35.8%) reported poor sibling relations.

Similar observations can be made about relations with friends and neighbors, in that 36.2% said that their friends lived far away and just over a tenth did not visit. As far as neighbors are concerned, well over half (55.6%) stated that they could not rely on them for help.

Finally, most indicated having spare or leisure activities which, except for church going, were essentially sedentary—television watching

(33.3%) and listening to radio (63.9%). Further, membership in organizations was low (15.3%), with membership in religious organizations (37.5%) being far more likely than membership in political, social, or financial clubs.

Retirement and employment is the fourth main aspect of social life among females aged 75 and over that this study investigated. The data show that the vast majority (77.3%) were retired, and that of these over two thirds (69.0%) indicated that their retirement was compulsory. A fifth of these (20.7%) said they were not happily retired, and just over a quarter (27.6%) said that financial problems were the main disadvantage of retirement. On the other hand, of the 22.7% who continued in active employment, the majority said that they did so because they wanted to rather than because they had to, and 80% were working for $30.00 or less per week. Looking at health among the respondents, just over a third (35.2%) subjectively perceived themselves as being in good health. An objective health assessment indicates that 45.2% reported suffering from arthritis, 38.9% from hypertension, and 20.5% from diabetes. Eyesight problems (47.9%) and loss of memory (45.2%) affected sizeable proportions as well.

Looking more specifically at patterns of medical care, a large majority (84.7%) did not visit a doctor within a two-year period, but when they did, more sought private (53.0%) than public (47.0%) medical care. Over half (55.9%) were on medication at the time of the interview, of which 13.2% were self-prescribed as opposed to prescribed by a doctor, while just over a quarter (26.3%) indicated that medication noncompliance was a problem.

In examining social policy programs for the elderly, we wanted, among other things, to find out how knowledgeable the respondents were about programs such as the old-age pension scheme, the free-bus-pass scheme, the district hospitals, the National Insurance Scheme (NIS), and the home-help service, whether or not they had ever benefited from these, and what specific experiences they had in doing so.

Analysis of the data show that many know about the existence of these programs: 53.4% knew of the home help service and 65.8% knew of the NIS (65.8%), the programs they were least likely to have heard about. With respect to getting benefits from the scheme, just over three quarters (79.5%) benefited from old age pensions and just over a third benefited from the free-bus pass; very small proportions reported getting benefits under the other schemes, with 2.7% listing home help and 1.4% the district hospital. It is interesting to note that very few of those who received benefits had complaints about the service received. However, at a more general level, there was a clear expression of a need for more financial assistance (75.0%), and for help in the home. Just over a quarter of the respondents (29.2%) said that not enough was being done for the elderly.

Turning to the data on the attitudes of respondents to death and dying, it emerged that a large majority (68.6%) did think about death, and just under half (45.1%) said they talked about it, with about one quarter (26.4%) saying that they had made plans for death. Only 5.6%, however, did say that they feared death.

On further analysis, we were able to show how females aged 75 and over compare with the total elderly population by comparing the above findings with those from the main survey. Table 2 shows that old old females seem generally worse off than the population aged 65 and over on the basis of economic indicators, social and psychological indicators, social relations indicators, and health indicators. A quick glance at Table 2 demonstrates that there are instances where the percentages in the column for females 75 and over are larger than the corresponding percentages in the column for the survey sample (see items 1, 2, 3, 4, 8, 9, 16, 25, 27, 30, 31, 32, 43, 44, 45, 46, 49, 51, 52, 57, 62, 63, 64, 65, 66, and 71). On the other hand, they fare better than their counterparts in the elderly population on items 6, 12, 17, 18, 21, 26, 33, 42, 47, 58, 68, and 72.

SUMMARY AND CONCLUSIONS

The analysis of the subsample's data offers clear indications that help us identify specific areas of disadvantage and dislocation. As in the case of the general survey, some interesting observations emerged: for example, unexpectedly large proportions lived alone and continued in active employment. In terms of the economic indicators, income deprivation was the major problem, but there were also residual problems in housing (especially in relation to the state of repair) and in food and nutrition, where quality of meals, not number of meals, seemed to be the problem. An interesting observation emerged in relation to the assumption about the degree of connectivity and supportiveness in third world societies. There is no denying that support networks exist, nor can we deny that they function as support agencies, but income support is definitely not one of their major areas of activity. There is also evidence of social isolation and loneliness. At the social and psychological level, the evidence of positive rather than negative self-concepts and a present and future rather than past orientation fundamentally contradict findings in North American and European societies.

Table 2. Comparison (%) of social life of a subsample of females aged 75 and over with that of all elderly people on a number of indicators.

	Females 75 & over	Survey sample
(a) *Economic indicators*		
1. Dissatisfaction with economic circumstances	42.7%	31.9%
2. Weekly income of less than $50.00	86.7%	75.1%
3. No pension income	29.2%	24.0%
4. No earned income	71.4%	65.6%
5. No income from relatives	63.9%	65.8%
6. No income from friends	86.1%	91.6%
7. No income from other source	84.5%	87.0%
8. Weekly expenditure of $50.00 or less	48.2%	41.8%
9. Dissatisfaction with food situation	33.8%	10.1%
10. Get less than two meals per day	21.9%	18.5%
11. Had no breakfast	11.1%	11.0%
12. Had no lunch	4.4%	15.0%
13. Had no dinner	20.0%	23.0%
14. Low protein breakfast	42.6%	40.2%
15. Low protein lunch	16.4%	15.5%
16. Low protein dinner	50.0%	38.8%
17. Low protective food breakfast	69.4%	82.5%
18. Low protective food lunch	51.5%	56.5%
19. Low protective food dinner	80.0%	81.3%
20. Dissatisfaction with housing conditions	17.7%	18.5%
21. Nonownership of house	11.4%	18.0%
22. No piped water supply	8.1%	8.3%
23. Other toilet facilities	—	2.2%
24. No gas/electric cooking supply	39.7%	37.0%
25. No electric lighting supply	33.4%	19.0%
26. No access to a motor car	61.6%	75.2%
27. No access to a refrigerator	36.5%	28.7%
28. No access to a telephone	47.3%	44.0%
29. No access to a radio	31.1%	23.8%
(b) *Social psychological characteristics*		
30. Concerned about crime	36.2%	27.4%
31. Concerned about lack of social care	23.4%	2.0%
32. Labeled old	71.2%	55.0%
33. Labeled old girl	35.2%	52.9%
34. Negative self-concept	5.0%	5.5%
35. Happy with religious nature and country	12.7%	12.0%
36. Happy with improvement and country	11.1%	14.2%
37. Happy with freedom and country	11.1%	11.0%
38. Perceived public negativism	68.7%	67.2%
39. Dissatisfaction with social treatment	53.0%	49.9%

Table 2. (Continued)

	Females 75 & over	Survey sample
(b) *Social psychological characteristics* (Cont'd)		
40. Young people treated better than they	82.8%	84.1%
41. Things have gotten worse	31.1%	31.0%
42. Did not realize life ambitions	46.4%	52.6%
43. Past-oriented	18.5%	10.9%
(c) *Social relations indicators*		
44. Single person household	31.5%	27.1%
45. No children alive	38.4%	24.7%
46. No contact with children	29.4%	20.7%
47. No help from children	13.6%	24.8%
48. No contact with grandchildren	30.5%	18.3%
49. Bad relations with spouse	61.5%	33.3%
50. Experienced feelings of loneliness	38.9%	38.0%
51. No contact with siblings	30.2%	23.3%
52. Friends far away	36.2%	10.8%
53. No visiting to or from friends	11.2%	12.5%
54. Cannot rely on neighbors	55.6%	58.4%
55. No spare/leisure time activities	6.8%	5.0%
56. No organizational membership	84.7%	79.0%
(d) *Employment and retirement*		
57. Not retired	22.7%	15.2%
58. Not happily retired	20.7%	34.5%
(e) *Health indicators*		
59. Subjective health not good	64.8%	62.2%
60. Had arthritis	45.2%	43.4%
61. Had hypertension	38.9%	41.4%
62. Had diabetes	20.5%	15.7%
63. Had eyesight problems	47.9%	17.4%
64. Had memory problems	45.2%	4.7%
65. Had not visited doctor in years	84.7%	22.7%
66. On medication	55.9%	45.0%
67. On self-prescribed medicine	13.2%	12.8%
68. Noncompliant behavior	26.3%	46.0%
(f) *Attitudes on death and dying*		
69. Talked about death	45.1%	44.2%
70. Fear death	5.6%	6.4%
71. Think about death	68.6%	60.8%
72. No plans for death	73.6%	81.1%

The attempt to compare old old females with the general elderly population confirms the view that the circumstances of this group, especially regarding economic conditions, social relations, and health conditions, seem to deteriorate rapidly in the later years of old age. Of course, exceptions should be noted; this can be done by reviewing Table 2 and identifying areas where old old females compare favorably with the total elderly population.

The social policy implications of the findings are pressing. The need for more, and more accessible income maintenance, health care, and social support services is self-evident, and need not be detailed here. However, because of the specific problems confronting this group, social policy approaches will have to be adjusted. For example, while it is true that there is greater network support within this group, it is also true that they are far more likely to express a need for social care facilities, and to express dissatisfaction with the services in this area.

Equally important, they are far more likely to live alone and to be widowed, posing specific problems for social care. To the extent that the need for social care is a major problem, and to the extent that the family network is undergoing change through geographical and social mobility, there is a clear need for alternative network support arrangements. Finally, the degree of fear of crime (36.2% among old old females, compared to 27.4% among all old people and a mean 3.7% in the total population) among this group suggests the need for urgent social policy initiatives in this respect.

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INFORMAL SUPPORT SYSTEMS OF WIDOWS OVER 60 IN PUERTO RICO

Carmen Delia Sánchez[1]

INTRODUCTION

Puerto Rico's progressive increase in recent years of the aging population, particularly aging women, has created a need to study this population group from different perspectives. The population 65 years and over increased from 2% in 1898 to 8% in 1980. According to the 1980 population census, there were 357,504 persons 60 and over in Puerto Rico. The increase in the 65 and over population during this century has been greater for females than for males.

Greater male mortality from the time of birth partly explains why there are more women than men at older ages (Carnivali and Calzado, 1986). According to the 1980 census, there were 91 men for every 100 women aged 65 and over. This imbalance between the sexes increases with age. In the 65-75 year age group there were 94 men for every 100 women, while in the 75-85 group there were 84 per 100, and among those 85 and over there were 71 per 100.

Widowhood is more common among women than among men. The difference in male and female life expectancy (seven years in favor of women) may be one explanation for this phenomenon, along with the facts that women generally tend to marry men between five and seven years older than themselves and that widowers are more likely to remarry than women, as shown by marriage statistics. In 1980 there were 20,000 widowers and 65,000 widows older than 65 in Puerto Rico; that is, one widower for every three widows. Close to 20% of all the widows lived alone (1980 census). Whereas 63% of the men live with their spouse when they reach 65 years of age, only 30% of the women of that age do. This shows that while most elderly widowers spend the last days of their lives in the company of their spouses, elderly women spend seven to ten years of their lives living alone.

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This demographic picture shows us a high concentration of the female population living alone during their older years. This is accompanied by cultural patterns that traditionally have conditioned women to a pattern of dependency on men, a pattern even more pronounced in the older population. These patterns are broken in widowhood, and the woman finds herself compelled to depend on other support systems. A 1978 study by the Commission for the Improvement of Women's Rights looked at the situation of the widow who faces the loss of her husband, her home, and her friends. In light of this situation she must form other social systems and look for new emotional supports to maintain her self-esteem.

There is no doubt that the circumstances surrounding the life of the aging widow demand the use of "significant others" with whom to interact emotionally and practically. This situation was what motivated this researcher to propose this exploratory study. Furthermore, research on aging widows in Puerto Rico is almost nonexistent. The present study attempts, among other things, to increase our knowledge about this group of women.

REVIEW OF THE LITERATURE

The informal support system has been defined as an amalgam of informal services provided by the elderly person's family, friends, and neighbors. This subject has been the object of research by several investigators such as Elaine Brody, Helena Lopata, Amy Horowitz, and others.

The family, according to Caplan (1974), is the main support in this system, since it is the main source of emotional guidance that the older person needs in times of crisis. People in need of help first turn to systems of informal support. Family, friends, and neighbors provide approximately 80% of the support services needed by disabled elderly people.

Research on the family and the aged has consistently shown that the family provides most of the health care services to elderly people who suffer physical and mental disabilities (Townsend, 1965). The family's commitment to its elderly members is amply documented in the literature (Troll, 1970; Troll, Miller, and Atchley, 1979; Horowitz, 1982; Sánchez, 1987). Research also shows that in cases where there is no family contact, the elderly create a "pseudo-family" made up of friends and neighbors (Troll, Miller, and Atchley, 1979).

The results of various studies also corroborate the finding that the family bears the main burden in providing care to the elderly who have serious functional disabilities (Shanas, 1979; Brody, 1981). Accessibility to a family support system turns out to be the main factor in reducing the likelihood of institutionalization for persons who are chronically ill (Townsend, 1965).

The type of aid that the family provides to the elderly has been the object of various studies (Townsend, 1965; Blenkner, 1965; Horowitz, 1982; Frank *et al.*, 1981). It has been found that reciprocity or mutual aid is a crucial dimension in relations between the elderly and their children. Aid flows in both directions and may consist of help with shopping, housework, child care, advice, information exchange, moral support, and presents or money. A study by Shanas (1979) in the United States, for example, found that 70% of the elderly gave help to their children and received help from them. The activities carried out by the elderly person's informal support system can be summarized in three areas: emotional support, practical and financial support, and liaison activities with service agencies. Cruz-López and Pearson (1985) concluded that in the case of elderly Puerto Ricans, the type of support they most valued was respect or appreciation, unselfishness, and acceptance. In this study, 98% of the elderly pointed out the reciprocal nature of their support system with family and friends.

A review of the studies carried out among the elderly and among widows over 60 shows the existence of rather closed networks of support (Arseneault, 1986; Rook, 1987; Bankoff, 1983). The effectiveness of and satisfaction with the support received by the elderly depend on: 1) the quality of the support or type of assistance (Bankoff, 1983); 2) the degree of interaction or the symmetry in the practical interchange (Rook, 1987); and 3) the opportunity to give the specific support offered (Shinn et al., 1984).

Other studies have pointed out the concepts that would best explain satisfaction with the network: the number of persons in the network, frequency of church attendance, and the number of persons considered to belong to the network. Furthermore, a strong relationship has been established between educational and economic level and a positive appreciation of the network and the number of network members (Ferraro, 1986).

Studies of widowhood have found that wide support networks where family and friends interact do not provide good support in adjusting to widowhood, particularly regarding state of mind, self-esteem, and other adjustment indicators. On the other hand, a smaller network, with more involvement of persons outside the family, allows the woman on her own to develop new social roles appropriate to her new status (Gottlieb, 1980). There is some agreement among researchers that the widow's support network is essentially composed first of the children, and second of siblings (Lopata, 1978; Anderson, 1984), cousins, nieces, and nephews (Lopata, 1978). Arseneault (1986), for his part, indicates that daughters offer greater support to their widowed mothers than do sons.

Some studies focus on deficiencies in widow-children relationship, and indicate that mothers consider that their relationships with married children are destroyed because they feel they interfere in their offsprings' family lives (Talbott, 1986). It also has been found that widows have more reciprocity in their relations with friends than with their children (Rook, 1987). The people with whom widows establish new relationships most easily are other widows (Gibbs, 1985). Other studies of elderly widows found that they feel more satisfied in smaller networks with family members (Hansson, 1986) and that they prefer to live alone (O'Bryant and Nocera, 1985). Shanas (1979) suggests that for the elderly with no children, other family members such as nephews, brothers, nieces, and sisters fill the role that children would assume.

Powers and Bultena (1976) also demonstrated the validity of the principle of family member substitution by showing that widows had a greater degree of intimacy with friends than did elderly married women.

STRUCTURE AND FINDINGS OF THE STUDY

This research project was named *The Informal Support System of Widows Over 60* and was carried out by the Graduate School of Social Work of the University of Puerto Rico. The study was completed in April 1988.

This type of study assumes the existence of an informal support system among elderly widows, and a dynamic interaction between the widows and the informal support system. It also assumes that widows, with their special characteristics and needs, constantly carry out exchanges with their environment which may or may not facilitate their physical and emotional survival, and that this has an effect on their self-esteem.

The methodology used envisioned the collection of information on measurable factors such as income, housing, and services received, and on factors related to perceptions about their support systems, satisfaction with them, self-esteem, and reciprocity of help.

The study design was exploratory-descriptive and included a representative sample of seven multi-level apartment buildings in the San Juan metropolitan area. The total sample was made up of 150 widowed women between the ages of 60 and 94 who lived alone. The average age of the 150 widows was 75 years. More than 60% of the women interviewed were between 70 and 84 years of age. Some 53% of the widows interviewed had a ninth-grade or lower level of education.

Those who are now retired at 65 or more years of age were born around the 1920s. The prevailing cultural characteristics of the period, and those of most interest to this study, are, first, the lack of access to formal education; second, and closely related, the fact that the formal and informal education that they did receive was aimed at preparing them to be mothers, wives, and homemakers. This placed the women in a dependent position with men and at an economic disadvantage. About 6.7% of the group studied did not know how to read or write. This can affect not only women's employment options, but also their knowledge of how to claim the rights or benefits offered by the different social programs that exist in the country. Having worked outside the home could have assured them a higher income than having to depend on social and other types of aid. It is important to point out that 29 of the widows had conducted university studies, which is higher than the average expected for the elderly population in Puerto Rico. In 1980 the average education of elderly Puerto Ricans was third grade of elementary school. This finding of a higher than average level of schooling may be related to the place where the sample was selected—private condominiums sponsored by professional associations.

Widowhood also has economic consequences. The income of elderly persons in Puerto Rico is, in general, extremely low in relation to the income of the general population, which in 1987 was $4,882. In the group of widows under study, 71.4% of them had a monthly income of $400 or less, which represents an annual income of $4,800 or less. Their poverty obviously results in this population having very limited access to the basic goods and services necessary to lead a decent life, regardless of age. Old age has turned into a factor of alienation within the Puerto Rican social structure.

Widows' participation in the workplace is minimal. A total of 147 of the 150 were out of the labor market. Only three were doing paid work on a part-time basis. Of these women who were paid for their work, those who had a high level of education limited themselves to working in professions considered traditionally female: secretary or volunteer teacher. The customary occupation of more than 50% of the women interviewed was homemaker; the rest had worked as teachers, secretaries, seamstresses, or in domestic service.

People 65 and over in Puerto Rico mostly depend on the income they receive from Social Security, the Nutritional Assistance Program, or their pension from the Associated Free State or private plans. Most of the widows in the study received income from Social Security (60%) or a combination of Social Security and pensions (20.7%).

Most of the widows (56%) had been widowed for more than 10 years. Only 14% had been widowed for three years or less. At the time they became widows, almost two-thirds of them (64.7%) had been married for 31 or more years. This group of widows can be considered self-sufficient. More than 65% of the widows believed themselves to be in good health at the time of the study.

The study confirmed what has been found in several previous studies. The main elements of older persons' support systems are their daughters and, failing them, their sons, sisters, daughters-in-law, friends, and neighbors. It should be noted that 44% of the widows interviewed did not have any children. The average number of children per widow was between one and two. Some 53% of the widows had grandchildren and they averaged five grandchildren per widow. A little more than three-fourths of the widows had relatives living within a half-hour's distance from home. It is notable that, for more than one-fifth of those interviewed, most of their relatives lived outside Puerto Rico.

In order to explore the use of the informal support system, the widows were asked who helped them most when they had health, economic, or personal problems. The findings in this area, listed in Table 1, showed that the daughters were the most likely to help with these kinds of problems. Following, in descending order, were sons, sisters, and neighbors. It

Table 1. Widows' designation of person who helps most with health, economic, and personal problems.

Person	Health frequency (%)		Economic frequency (%)		Personal frequency (%)	
Daughter	52	35.1	46	31.9	49	32.9
Son	22	14.9	30	20.8	23	15.4
Granddaughter/grandson	5	3.4	4	2.8	5	3.4
Sister/brother	18	12.2	12	8.3	13	8.7
Niece/nephew	7	4.7	4	2.8	6	4.0
Male/female friend	4	2.7	8	5.6	8	5.4
Male/female neighbor	20	13.5	2	1.4	16	10.7
No one	14	9.5	33	22.9	21	14.1
Others[d]	6	4.0	5	3.5	8	5.4
Total	148[a]	100.0	144[b]	100.0	149[c]	100.0

[a] Two widows stated they had no health problems.
[b] Six widows stated they had no economic problems.
[c] One widow stated she had no personal problems.
[d] Includes housekeeper, social worker, building manager, priests, or ministers.

can also be seen that the position occupied by sons as a support system is almost the same as that of neighbors. A high percentage stated that no one helped them when they faced the aforementioned problems.

Most of the widows expressed satisfaction with the aid received from their sons and daughters.

When the widows were asked in general terms to name the persons who most helped them, most of them mentioned their daughters. Table 2 shows in more detail the replies to this question. As can be seen, the largest percentage of the 150 widows interviewed stated that their daughters were the ones to help them. It can also be seen that the main support system was made up of women (73%), among them sisters, neighbors, nieces, friends, and granddaughters, in addition to daughters.

Table 3 shows the composition of the studied widows' close family. The table shows that for more than one-fourth of the widows, the immediate family is made up of daughters, sons, granddaughters, sisters, and brothers. Most of the women in this group of widows have an extended family. This corroborates the fact that the elderly continue to form part of the extended family, even though it is evident that families are getting smaller and smaller. It is notable that the percentage of widows who believe that their family is composed of their daughters and sons is the same as the percentage of widows who consider that their family is composed of their sisters and brothers.

Table 2. Widows' designation of who helps most in general.

Person	Frequency	Percent
Daughter	56	37.3
Son	23	15.3
Sister	18	12.0
Neighbor (female)	17	11.3
Niece	9	6.0
No one	8	5.3
Friend (female)	6	4.0
Granddaughter	4	2.7
Nephew	2	1.3
Grandson	1	0.7
Brother	1	0.7
Friend (male)	1	0.7
Others[a]	4	2.7
Total	150	100.0

[a] Includes housekeeper, social worker, building manager, priests, or ministers.

Table 3. Composition of widows' families.

Composition of family	Frequency	Percent
Daughters, sons, granddaughters, grandsons	44	29.4
Daughters, sons	16	10.7
Sisters, brothers	16	10.7
Sisters, brothers, nieces, nephews	14	9.3
Daughters, sons, grandsons	9	6.0
Daughters, sons, granddaughters, grandsons, other relatives	8	5.3
Daughters, sons, grandsons, granddaughters, great granddaughters, great grandsons, sisters, brothers	7	4.6
Daughter, sons, sister, brothers	6	4.0
Sons	6	4.0
Daughter, sons, mother	4	2.6
Nieces, nephews, son, others	4	2.6
Daughter, sons, granddaughters, grandsons, great granddaughters, great grandsons	3	2.0
Sisters, grandsons	2	1.3
Cousins (male and female)	2	1.3
Other combinations	8	5.6

The activities carried out by means of the widows' informal support system can be summarized in four major categories, listed in order of importance and frequency: emotional support, practical support, economic support, and liaison with agencies. Principally, the daughters and then the sons, sisters, and other family members were involved in other activities. Friends and neighbors provided mainly emotional support, which included visits, telephone calls, and advice.

Some 84% of the widows received visits from family members and in 65% of the cases the frequency of the visits was at least once a week. About 80% of the widows visited their family members in turn, 38% of them visiting at least once a week.

Table 4 shows the degree of correlation between the widows' visits from family members and those to family members. It can be seen that the widows in the study received visits in about the same degree as they made them, which establishes a pattern of reciprocity with regard to family visits.

The family members whom the widows visited most were daughters (36.3%), followed by sons (17.3%), and sisters (16.7%). Family members who visited the widows most also turned out to be daughters (39.3%), then sons (16.0%), and sisters (14.0%).

Regarding telephone calls, 87.3% of the widows talked on the tele-

Table 4. Correlation between number of visits to family members and number of visits from family members for 143 widows.

Visited by family members (n = 143)	Visits to family members (n = 143) Yes No. (%)	No No. (%)	Total No. (%)
Yes	113	6	119 (83.2%)
No	13	11	24 (16.8%)
Total	126 (88.1%)	17 (11.9%)	143 (100%)

Chi square	Degrees of freedom	Significance
27.95091	1	0.0000
31.72562	1	0.0000

phone to their family members, and 30% wrote them letters. Likewise, 45% of the widows received letters from their family members, and 60.6% received telephone calls from them.

Some 93% of the widows in the study maintained relations with people who were not part of their family, among them friends and neighbors. Most of the widows' friendships come from the neighborhood where they lived in their youth and during their marriage, places where they lived most of their lives.

An analysis of reciprocity with regard to visits from friends shows that 83% of the widows reported having visits from friends at least once a month, and they in turn (56%) visited their friends at least once a month. Those widows who did not visit their family members (17.3%) or their friends (23.3%) cited transportation problems as the main reason. Some 72% of the widows received calls from their friends once or twice a week.

Some 99% of the widows reported that they knew their neighbors and had friendly relations with them. About 83% of them visited their neighbors at least once a week.

About 90% of the widows received visits from their neighbors at least once a week. Table 5 shows the relation between visits to neighbors and visits from them. It can be seen that there is reciprocity in the visits between the widows and their neighbors. The degree of significance is 0.0001. Some 95% of the widows stated they had good relations with their neighbors and were satisfied with those relations. The widows in the study were generally satisfied with the frequency of visits and calls, both from family members and from friends and neighbors.

Table 5. Correlation between number of visits to neighbors and number of visits from neighbors for 150 widows.

Visited by neighbors (n = 150)	Visits to neighbors (n = 150)		
	Yes	No	Total
	No. (%)	No. (%)	No. (%)
Yes	119	6	125 (83.3%)
No	17	8	25 (16.7%)
Total	136 (90.7%)	14 (9.3%)	150 (100%)

Chi square	Degrees of freedom	Significance
15.14181	1	0.0000
18.21428	1	0.0000

CONCLUSIONS AND RECOMMENDATIONS

The study described herein has focused on the informal support system of widows over 60. It has yielded important data that may be of help in developing programs and public policy in relation to this population group.

The existence of an informal support system composed of family members, friends, and neighbors has been amply documented in the study. It has shown the importance of the informal support system for the well-being of elderly women. Besides showing the extent of the support services provided by the widow's family, friends, and neighbors, this study suggests the need to strengthen these support systems. This can be done in the form of education or orientation, or in the form of economic incentives to the family to provide practical aid to widows so they need not exhaust their personal resources. It is necessary to develop and strengthen the family and social support networks of the elderly in order to facilitate their development and offer them the emotional support necessary to confront the conditions and changes characteristic of this stage of life.

Such factors as the lack of economic resources and academic preparation, together with sex and age discrimination, put the elderly widowed woman in the poorest and most limited population group in our society. It is generally said that the problem of poverty in old age is concentrated in women because a high proportion of elderly women are widows and live in poverty. Although widowhood increases the likelihood of falling into poverty, it is not widowhood in itself, but society's attitudes toward widows, that cause this situation. This is an area of public policy that merits fundamental attention.

In addition to the problem of physical and emotional isolation, the aging widowed woman must confront new roles for which she has had no previous preparation. This raises the need to develop programs or services aimed at training the elderly widow to face her new role and remake her life. This includes the need to retrain or educate her not only to prepare her for basic issues of daily life, but also so that she can work at some type of job that will give her an income to support herself. In the case of the woman who is already very old, these programs would have to be aimed at preparing close family members or social agencies to meet these needs. The elderly woman's solitude is aggravated by the lack of an adequate transportation system that would allow her to go to recreation centers or to visit friends and relatives.

As part of this task of reorienting the elderly widow, she should have the opportunity to join with others and fight for her rights and for solutions to her problems and needs. She should be encouraged to participate in all the decision-making processes that will affect her life in our society.

The responsibility of the children has been emphasized in this study. This is a subject that is very important for public policy in regard to the elderly population. Filial responsibility is a value that is still strong and plays a significant role in our society. This is the basic motivation of children when they respond to a parent who needs care, whether there is any recompense or not (Horowitz, 1982).

This study has documented the prevalence of the value of filial responsibility. This finding is consistent with those of Adams (1968), Brody (1981), Horowitz (1982), and Sánchez (1987) who found that obligation, love, and reciprocity are principal components of the relationship between children and their aging parents. An important result of this is that, for the elderly and particularly for elderly women, filial responsibility may color official perception of needs for services. For example, the notion that the family cares for its elderly members is a double-edged sword when planning long-term care services or institutionalization for the elderly. This assumption can be used to justify not providing services that the aging women need to continue functioning adequately in the community.

In general terms, additional longitudinal studies need to be conducted in order to provide a national picture of the impact of old age and widowhood on women; these studies should explore, among other topics, how women see the events in their lives related to widowhood.

This study has documented that daughters are the main source of support for widows; it also is important to explore how women's entry into the work place affects both widows and their daughters. By the same token, many widows do not have surviving children; therefore, it is also necessary to examine their support systems in the absence of children.

An examination of older women's support systems is, without doubt, a way to examine their needs and the realities of their lives. In turn, the role that these women play by virtue of their support systems enables them to see themselves as significant in relation to their family, which in turn increases their self-esteem and allows them to remain an integral part of the family structure.

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PSYCHOSOCIAL PERCEPTIONS OF THE STATUS OF WOMEN OVER 45 IN COLOMBIA

Elisa Dulcey-Ruiz and Mónica Segura-Barrios[1]

> When I get old—if ever I should—and I stare in the mirror and count my wrinkles, like a delicate mountain range of distended skin. . . . I know that my heart will still be—defiantly—ticktocking, and questions and wide horizons will also greet my mornings.
>
> Giaconda Belli (*Challenge to Old Age*)

The perception of adult and older women throughout history, especially in Colombia, is introduced from an alternate view of gerontology, considering the historic and sociocultural context framed by what could be considered a psychosociology of Latin American fatalism. We review some studies made during the 1970s and 1980s which, in different ways, take into account the present and prospective perception, social portrayal, and/or image of the woman over 45 in Colombia. The earlier studies, mostly traditional ones, mainly search for information; the more recent ones, though less systematic and with a more qualitative emphasis, depart from a common-sense knowledge of social portrayals and try to foster reflection, inquiry, and action as a way to change stereotypical perceptions and alienating conditions pertaining to being an adult or older woman. Likewise, from a dialectical perception, we emphasize the importance of having the very subjects under study analyze psychosocial perceptions. In the same vein, we propose as one of the frameworks for analysis and transformation, the model of *integration* (independence, activity, and social participation) as opposed to the model of *alienation* (dependence, passivity, and isolation). This model should serve as a foundation for policies on education, health, and general quality of life for women, which are beginning to be developed in Colombia. We raise the need to continue such activities, working *with* all social groups regardless of their age, and considering that the so-called *older* and *advanced* ages depend in large part on previous conditions and styles of life.

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Development (evolution) and aging (involution) are simultaneous and ongoing processes which are an essential part of life from conception to death. These two processes, as well as maturity and old age, depend on biological heredity, on our personal and family lifestyle, and on the historical, economic, and sociocultural circumstances in which we live. Thus, they generate conflict and change as well as being affected by situations of conflict and change. These are *not* an optional part of life: whether we want to or not, whether we are aware of it or not, whether we recognize it or deny it, we develop and age from the beginning of our lives until death. In the same way, we become adults or older persons, sometimes without even accepting or being aware of it. However, what *can* be considered at least partially optional, not only in a personal sense but also in a family and sociocultural context, is the *quality* of our development, our aging, our maturity, and our old age. And it is in regard to the latter that it is worthwhile to emphasize the role of the so-called *alternative gerontology* (Dulcey-Ruiz, 1987, 1988): faced with a reductionist, nonhistoric, out-of-context, and pathological view of aging and old age (survival gerontology), the alternative gerontology takes aging and old age to be constructions in which both the person and his or her historic and sociocultural context participate and accept responsibility, in order that these events will be accepted and enjoyed by each human being, rather than suffered or manipulated by others.

SEX AND AGE DIFFERENCES

As the sexual beings that we are, it is appropriate to consider here the difference between biological roles (unchangeable, at least in large degree) and social roles (modifiable). The fact is, we are born as women or as men and there is nothing, or at least very little, we can do about such a biological event. Society, however, attaches certain characteristics and designated roles to one or the other sex. Thus, it is expected that men, from the time they are children, will not cry, will be strong, will play with cars and guns, and will be outside more than in the house; while women are expected from the time they are children to be weak, dependent, to play with dolls and kitchenware, to stay at home. Of course, what is considered typically feminine and masculine varies from one society to another (Oriol Anguera, 1975). That is, social roles are relative, though sometimes—perhaps too often—they are taken as absolute and unchangeable.

The same thing could be said regarding age differences. Despite sociocultural stereotypes that characterize older persons as a homogeneous group, alienated, and disadvantaged, it is surprising to realize that adult and older persons are rather heterogeneous populations. This is so true that any person at a designated age is more like himself at earlier stages in his life than like another person of his same age. This does not imply that there are no permanent changes in the course of life.

WOMEN AND OLD AGE IN THE LATIN AMERICAN CONTEXT

With the foregoing frame of reference, it may not be surprising that allusion to the psychosocial perception of women over 45 in Latin America, and specifically in Colombia, needs to be placed in a historic and sociocultural context. Above all, one must remember that Latin America, and certainly Colombia, emerged from the impact between two distinct cultures: the indigenous and the Spanish. The exact history of the indigenous woman, as well as that of the mestiza or of the Colombian woman in general, is, for the most part, still to be written. Nevertheless, in one way or another, we *all* carry it inside us: it is a history full of contradictions, which mixes features both praiseworthy and ignominious. Simultaneously they are dreamers; creative; risk-takers; stubborn; submissive, though with tireless longings for independence; capable of facing countless challenges without number—historical, physical, familial, social, cultural, personal; in constant search, moreover, of their self-identity which, even today, often seems to evade them. And all of this, including fatalism, oppression, submission—what we most deplore—we regretfully continue to share.

To be a woman and to be old, as shown by Lehr (1982) and Lesnoff-Caravaglia (1984), is still, even in many so-called *developed* contexts, a disadvantage or a social stigma. In areas such as Latin America that are economically less developed but more cohesive with regard to family and society and where the extended family persists to a larger extent, older persons still find acceptance, affection, and respect. Nevertheless, as shown by Dulcey-Ruiz and Ardila (1987), the traditional ways of life, the wisdom attributed to the old, their place as the center of family ties, are being progressively lost with modernization. In this sense, Latin America has come to be much like and to incorporate several aspects of the philosophy of the so-called *developed* countries. And thus, also among us, being a middle-aged or older woman has in some way come to be a stigma, a disadvantageous social fate, and even an unenviable biological fate unfairly associated with many limitations and obligations but comparatively few satisfactions and rights.

A study by Omar (1987) in Argentina on the perception of old age by persons of both sexes and different ages illustrates the foregoing. Omar found that: (a) regardless of the sex of the respondent, the beginning of male old age was placed after the beginning of female old age; (b) both aging and old age were considered to be determined principally by organic conditions, that is, the first association prompted by the term *old age* was biological—and usually detrimental (loss of vigor, of physical appeal, of reproductive capacity); and (c) the perception of one's own aging and old age, understood above all as a biological diminution, was contrasted with the perception of some type of psychological and/or social enrichment (greater experience, for example). Another interesting contrast was made between the unfavorable perception of *old age in general* and the favorable perception of *one's own old age*.

MINORITY FEMALE PSYCHOLOGY AND LATIN AMERICAN FATALISM

It is paradoxical that, even though we women have a greater life expectancy than men and constitute the majority of the world's adult and older population (United Nations, 1983), we exhibit a typical minority psychology which combines the already noted discrimination by sex and age, and which is even accepted by women themselves. Acceptance of this as a condition about which nothing can be done coincides with a fatalistic attitude (from the Latin *fatum* which means *inevitable destiny)* tied in some way to our historical baggage and characterized, among other things, by the belief that: (a) life—our life—is predetermined; (b) nothing can be done to change this destiny but to resign oneself to it; and (c) this inevitable destiny is attributable to uncontrollable forces—such as a distant God, impersonal and remote—before which one can only be passive, conformist, and submissive. Such a fatalistic attitude, described in detail by Martín-Baró (1987), conforms to characteristics of cultural underdevelopment such as living in an eternal present, with no memory of a personal or a sociocultural past, and, consequently, without profiting from experience, without setting goals, and without planning for the future: an eternal present—as affirmed by Martín-Baró (1987)—not so much to fully enjoy the present moment, but to be indifferent to even the most immediate future.

The foregoing does not imply historical stagnation or the absence of change, since what we are trying to reconsider is the way of seeing these changes, especially when we refer to the psychosocial perception of women at midlife and older in our milieu. Appreciating this change can mean to question it and to accept it on reflection, or simply to endure it noncritically in a fatalistic way. The latter attitude is what we are interested in analyzing, questioning, and transforming. To do this, we have begun to act by removing the myths about aging and old age for both sexes, conscious that "great revolutions do not repress, but manage to make people think, feel, and act in a different way."

STUDIES RELATED TO THE PERCEPTION OF AGING AND OLD AGE

Since the 1970s systematic studies have been made on perceptions and attitudes about old age in Colombia. An analysis of them shows their concern for participatory and contextualized forms of research which seek to involve the study population so it will be able to transform its own reality.

One of the first studies (Dulcey-Ruiz and Ardila, 1976) concerns attitudes towards older persons of 200 young university students of both sexes and 200 older persons, mostly women in institutions. In general, all the subjects revealed negative attitudes, the most negative coming from the older institutionalized women. García de Muñoz *et al.* (1982) studied the attitudes towards menopause of 80 Colombian women with intermediate and university education, who were divided into two age groups (18–34 and 35–67). No significant differences were found between the two groups. In general, attitudes were negative, particularly among the older women. The young women and those of university level revealed a less negative attitude.

In an analysis of Colombian newspapers, Jaramillo and Dulcey-Ruiz (1983) found few references to old age, most of which referred to men and featured situations of death, violence, shelter, and abandonment.

Jiménez *et al.* (1985) studied attitudes towards sexuality in old age of 120 middle-class people with secondary and university studies who were divided into three age groups (20–25, 40–45, and 60–65). They found significant differences by sex and age, the most negative attitudes being expressed by the youngest and oldest females.

The Gerontological Psychology Center (1985) studied the image of old age as presented in the press, on radio, and on television. Analysis of the data revealed that the subject was treated very little in the media; in any case, old age among women was underrepresented, especially in the press and on television. A marked predominance was found in the categories of active old age and socially participatory old age, in that order. Despite the foregoing, a dependent image of old age stood out, particularly of female old age, except for portrayals on the radio.

During 1986, 1987, and 1988 Dulcey-Ruiz studied the social portrayal of *old age in general* and of *the prospects of their own old age* in 120 mostly female students who were completing a psychology degree at two private universities in Bogota, Colombia, and found, as did Omar (1987) in Argentina, that they associated *old age in general* with mostly unfavorable physical aspects and with detrimental psychological and social aspects; and they portrayed *their own old age* emphasizing psychological and social aspects such as independence, activity, friendships, and family.

An analysis of studies such as this one leads us to see that extreme situations that are commonly rejected, such as old age, illness, and death, tend to be perceived less negatively when they relate to oneself. This agrees with psychosocial hypotheses that suggest an inclination to attribute successes to oneself and to attribute failures to impersonal sources (Roldán and Riso, 1987).

Other studies carried out during 1988 (Santo Tomás University and Javeriana University) with different groups of students (from preschool to nursing postgraduates) reveal images of older women in which physical disadvantages, as opposed to psychological and social advantages, predominate, which also agrees with the findings of other studies, such as the one by Omar (1987) in Argentina.

PERCEPTIONS OF WOMEN 45 AND OLDER

Children, young people, adults (including high school and university students as well as some workers, prisoners, and rural people), and the old of both sexes described the image of a woman 45 years of age or older with pictures and/or in words. Except for a group of industrial design students, the subjects preferred to talk rather than draw. Girls between 10 and 16 years of age emphasized stereotyped physical characteristics, both positive (pretty, elegant, rich) and negative (sick, humpbacked, crippled). On the other hand, 83 students in the first semester of psychology, mostly women, emphasized positive psychological characteristics (experience, maturity), while they pointed out physical characteristics such as wrinkles, gray hair, motor and sensory deterioration, as well as social aspects related to roles within and outside the family. Only a few considered that the changes and characteristics were related to previous conditions and lifestyles. The latter would indicate a perception of personal and social (internal) rather than an external *(fate)* control. A few of the women over 60 who were interviewed remembered being 45 as a healthy and active period, and as a time of enjoyment, especially with the family. Most of them asserted that old age had caught them by surprise; while they remembered having felt, in some cases, compassion and respect for older persons, they never thought that they themselves would one day be old.

A small group of farmers characterized the woman of 45, regardless of her marital status, as a strong but not very attractive worker on the farm and in the family. In contrast, some city workers considered her productive in work, though limited by her age, as well as a "concealer" of her aging "since scientific advances make it possible" (Santo Tomás University, 1988).

OTHER RELATED STUDIES

With respect to menopause, work was done with female psychology students, female staff from the administration of social institutions, and female postgraduate nursing students as well as some young male university students and independent workers. In all groups menopause was mainly perceived as a female biological event, with possible psychological implications. A greater level of knowledge and acceptance was observed on the part of the psychology and nursing students. A little more than half the men studied (16) expressed clear ideas about menopause, while others related it with an inability to have sexual pleasure and even thought that they themselves would go through menopause—characterized, in some cases, by "sexual impotence" (Dulcey-Ruiz and Segura, 1988).

From a slightly different perspective, and using the method of autobiography with future projection, Segura (1988) analyzed the reports made by a group of 30 female high school students (with an average age of 14 years) of a low socioeconomic level and found a predominance of allusions to traditional female roles (getting married, taking care of the husband, having children), with few references to work outside the family and very few to intellectual pursuits.

DISCUSSION AND PROJECTIONS

The use of alternate forms of research to obtain greater depth and participation, even if they mean lower population coverage, has become a basic tool in research and education. By analyzing common-sense knowledge (social portrayals), autobiographies with future projection, and story telling, taken as a basis for discussion and comparison with other points of view (including scientific knowledge on aging, old age, sexual roles, and other aspects), we are focusing on activities that are more formative than informative, more personal and participatory than impersonal and remote. As a basis for such activities we have proposed a *model of integration* (independence, activity, and social participation) as opposed to a *model of alienation* (dependence, passivity, and isolation) in relation to aging and old age (Gerontological Psychology Center, 1985). And taking advantage of the aspects that are coherent with the model of integration found in our studies, we leave room to reflect on and to question preestablished and stereotypical perceptions.

We are aware of the need to delve into all fields, to evaluate our history and our conceptions, recognizing, as Restrepo (1988) points out, that in all peoples and institutions—including, of course, Judeo-Christian civilization—and in every period, there have been situations in which women and older women have been undervalued. Women have been considered only in terms of their biological roles, their physical charms, or the loss of same, while at the same time widowed women have been pitied for their supposed loss of protection, often causing them to be undervalued and dependent. But there have also been other peoples and institutions that have championed the value of both sexes, as well as the value of more structural and personal characteristics—especially in the case of women. These have questioned stereotyped views and have emphasized human life as a personal and social construction that implies "good times and hard times" and a permanent possibility for development and differentiation.

Then to whom, and in what direction, should we aim our efforts? We believe that everyone—women and men of all ages, within and outside institutional spaces—should become aware that socialization increasingly extends beyond institutional spaces. Socialization includes informal realms: art in general, music, songs, the theater, the cinema, and the communications media, among many others, whose messages so often dull our reflection and our critical capacity, becoming distractions that alienate, or alleged educators that bore, but are rarely satisfactory teachers.

Thus, the changes we invoke in the name of an *alternate gerontology* (Dulcey-Ruiz, 1987, 1988) seek to recreate values and to clarify obscure views, such as those that associate *old age* with a fatal destiny, depression, pity, and illness and that associate *women* with dependence and disability. We believe in the need to fight against age and sex discrimination and in the need to recreate and redistribute opportunities, activities, and social roles in a more flexible way among persons of both sexes and all ages.

Thus, among the activities planned by the Gerontological Psychology Center are some that are specifically related to educational research and to the promotion of comprehensive health and a better quality of life. Work will be done with women employed by companies (before and after retirement), with widowed and separated women, with women who live in institutions and in the community. In order to do this, we take as a basic assumption that the position a person assumes in life vis-à-vis his or her development, aging, old age, sexuality, and sexual role depends in good part on the perceptions, beliefs, and feelings he or she has about them, which, of course, are not predestined but belong in a historic and sociocultural context.

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FEMALE SEXUALITY AND AGING IN COLOMBIA

Argelia Londoño Vélez[1]

INTRODUCTION

This work is the product of my relation with a group of women—pensioners, homemakers, and wives of pensioners—who agreed to talk about their perception of the aging process and their experience of sexuality.

The work was carried out during six consecutive months in 1988, in an intensive effort to come to know the personal, internal life through which we were discovering, they and I, the threads that bound their experience of sexuality.

In the workshops we came to conquer our own fears and built a human relationship of solidarity that allowed us to gather information never before confessed, to resolve doubts, and to collect points of view about sexual activity and the fact of being women.

To these women I offer my everlasting affection, and to the reader I offer the wish that this interpretation of what was heard and said from the vantage of old age will serve us in our own future.

AXES OF SOCIALIZATION

The family is the place of socialization *par excellence;* it is where the process of transmitting and learning norms, customs, behavior, and attitudes is carried out. It is there that genders are constructed, where what it means to be a man or woman is produced and reproduced.[2]

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[2] We make a distinction between *sex* and *gender*. The former is related to biology, to the quality of being male or female; the latter is the category that refers to the construction of the male and female identity, which is culturally determined.

Gender construction refers to the assignment of roles, parts, places, and differing expectations to men and women. Gender is constructed as a multidimensional relation:

- the relation with the other gender;
- the relation with the same gender;
- the relation with oneself as a member of a gender.

The family is the transmitting agent for models of relations experienced in real life as approximations or deviations from these models. In this sense, the family proposes and imposes a model of the relation between the genders and develops a series of practices which its members, according to their gender, internalize.

The model of sexual experience, considered as a gender experience, is articulated around a group of values that evolve into concrete practices and expectations.

To conceive of sexuality as a social relation between the genders is to go beyond its conceptualization as anatomy and physiology, as reproduction of the species, or as sexual relations, coitus, and genitality.

Within this framework, we worked with a group of 35 women regarding their experience of sexuality as a relation between genders, how they lived the female construct, how they experienced the internalization of the feminine as a gender.

Femininity evolves from exercising practices within the family unit. A group of values that gives them coherence and body is articulated around these practices. Wifeliness, domesticity, and maternity are the practices around which the model of femininity is articulated. Socialization leads to the adoption and internalization of the cultural model of femininity in such a way that it would seem to come from nature and be inherent to the woman.

Domesticity

Domesticity consists of practices aimed at the production of goods and services for the immediate consumption of the family unit; these practices are assigned according to a sexual division of labor. Domestic work is identified socially as feminine.

Under conditions of poverty, which is the case for 64% of the group, carrying out domestic tasks is the way one learns the roles and functions assigned to the female: food preparation, cleaning, hygiene, and maintenance of the physical space, clothing, and others, all carried out under difficult conditions.

Childhood for this group was not a time for play, but for socialization through work. It is a time of learning the duties assigned to the woman, a training for the future part they must play at the head of a new family unit in their role as wives.

The women referred to domestic tasks as their "destiny." "To fulfill one's destiny" is a typical expression to designate household tasks.

"Wifeliness"

The objective of apprenticeship in the domestic role is linked to the female future, to social expectations. The apprenticeship has two meanings: on the one hand, the immediate accomplishment of the tasks that fall especially on older women, and on the other, the intermediate or strategic meaning of learning how to do housework and take care of the home in relation to creating a new family unit where the woman will reproduce the functions learned in her socialization. "Marriage means taking care of the house, cooking for a man, and fixing his clothes." One leaves home to marry; a wife proves that she is good by doing domestic tasks, among other things. Seventy-five percent of the women were or continued to be married, and 25% of them were single.

Marriage is experienced as a vocation, and one comes to it in the role of servant to the husband. "I thought it was to fix the house, make the meals, have his clothes ready, and take off his shoes." With marriage, the woman assumes her husband's authority over her as something natural and unquestionable. In her role as wife, the woman makes herself into a performer of domestic tasks. In the new family unit she reproduces the role of wife learned at her mother's side. Socialized for the performance of domestic tasks and to be a wife, trained in these daily duties, she repeats and reproduces the maternal model. "I wanted to be a lady, just like my mother." "My mother used to say, 'Child, it's good for you to get married.'"

Maternity

> Matrimony is to marry and give thanks to those who are married who live in peace among themselves and raise children for heaven.
>
> (Catechism of Father Astete)

Maternity is the expression of a group of social, work, emotional, and moral conventions aimed at guaranteeing the survival, growth, and development of offspring, which culturally fall on the woman.

Maternity is not "to make children" so much as to raise them. Coming from homes with an average of 15 children, the women actively participated in raising their younger brothers and sisters; their socialization in the maternal role was carried out by means of real work in raising children. Though they were not so prolific as their mothers, with an average of 5.6 children, the maternal role also made up their destiny.

If we look at the number of children with relation to occupation or job after marriage, we find that while those who defined themselves as housewives had an average of 7.6 children, paid workers had an average of 3.[3] In the group of paid workers, it is important to point out that 50% of the married women began to work as young widows, which explains why they had fewer children. The remaining group suggests a correlation between small number of children and salaried employment.

There are two points of view among the single women. Most of them aspired and still aspire to get married if they find a mate who meets their expectations. Another group would no longer get married even though they wanted to at an earlier time, and another group expressed little interest in marriage. There were no single mothers in the group.

THE SOCIALIZATION OF SEXUALITY

I have briefly referred to the axes of socialization in terms of transmission and appropriation of roles and functions assigned to women and the construction of these as their natural destiny. I would now like to refer to the socialization of sexuality starting with a concept of the female body and how it dovetails with a relationship with the other sex.

Sex, Sexuality, the Unmentionable

It is forbidden to speak of sex and sexuality. There is no space or place inside the family where sexuality, or sex, can be talked about. Even though such talk is condemned, a concept is spread about the uses of the body and sexuality, a concept is disseminated regarding what is prohibited and what is permitted; it is transmitted by gesture, by attitudes, by prohibition of the unmentionable, or what is called "that" or "about that."

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[3] Facts and projections presented in 1987 from the Maternal-Child Program of the Colombian Ministry of Health point out the relation between fertility and employment in Colombia. Marital fertility rates for three different occupation groups were: 5.48 for women without occupation, 4.86 for family or independent workers, and 3.84 for women in other occupations.

None of the women in the group recalled any conversation about sexuality, its dangers, or its pleasures, nor about functions, organs, or needs. Natural functions of a healthy body such as menstruation found these women completely unprepared and uninformed. Though sex is unmentionable, it is also what is most expressly prohibited and most feared for its consequences.

Man: the Devil

Sex means man and he is the source of all evil and danger: "They're no good for you;" "They don't respect you;" "They're bad;" "They'll do you a bad turn;" "They love you and leave you;" "They manhandle you;" "They take advantage of you;" or "They have bad intentions."

Until marriage, the demoniacal view of man is emphasized; after marriage, what was previously prohibited becomes what must be permitted, the obligation that must be fulfilled by virtue of the sacramental tie. A man who respects women is one who doesn't make "wicked proposals" or who has good intentions. Evil and goodness in a man are measured according to his sexual demands on a woman together with the offer of marriage.

For her part, the woman who gives in to the man's demands is one who "gets knocked up." Giving in to sexuality is evaluated in terms of Christian morality about good and evil. Goodness is the practice of the virtues of the Virgin Mary; evil is breaking with those virtues.

Socialized in the prohibition of all sexual activity and without information of any kind, the woman comes to marriage bereft of any knowledge and with no previous experience. Ignorance is prized as innocence and becomes a virtue.

Values such as chastity, modesty, and virginity are held up as virtues when a man chooses a wife and mother for his children. Lack of knowledge and experience are considered positive attributes that can be demanded; experience in sexual matters is restricted to "easy" women.

"To fail" or "to fall" connote premarital sexual activity; they are expressions that denote the loss of sexual honor, virginity, and usually constitute both an individual and family disgrace. The woman must wear her virginity as a token of her mother's example, and the mother in turn expects that her daughters "won't fail her," "won't disrespect her," "won't do it."

To remain a virgin is an ideal, a goal, and an honor; thus, all the mother's efforts are directed toward setting up the man as the stalking enemy on the hunt for her daughters' virginity. In fact, it is a real danger because it means not only the loss of her virginity but a possible pregnancy.

Sexual activity is permitted only in marriage; after all, children must get there somehow. The single mother is a stigma that is difficult to pardon and is subjected to discrimination, exclusion, subordination, and all manner of social and family humiliations. She is a failure to her mother, to her family, and to herself.

Only one woman in the group lived in free union with a man, but she did not reveal this to the group. The others were virgins when they married, and all but one of the single women implied in some way that they were still virgins.

Ignorance of sexual functions is such that the women stated they had gotten married without even knowing what the sexual act was or where children came from. Socialization prohibits talk about sex, even reproductive sex linked with the institution of matrimony. Of the married women who said they had not known anything about marriage in terms of the sexual relations involved, the mean age of marriage was 22 years. Sexual relations are assumed to be an obligation or duty that must be fulfilled.

In such conditions, most of the women experienced marital sexual activity as a burden: "I do it because it's my duty;" "I did the best I could all the time, but it always seemed horrible to me;" "Marriage wasn't a good thing;" "The first months I was scared and ashamed;" "I did it but I thought it was immoral;" "There was a lot of fear, it seemed ugly to me;" "I never saw my husband naked;" "I never knew sex existed, I was blind when I got married."

The Dialectic of Yes and No

Sex-as-obligation is the opposite of sex-as-pleasure. The pleasurable aspect of sexuality emerges after some months of marriage, but only a minority experiences this.

The socialization of prohibition has a negative impact on the experience of sexuality. Furthermore, the woman is faced with the need to suddenly break with all premarital taboos. "No" (don't let him touch you, don't hold hands, don't kiss, don't talk, don't do it) must become "yes." "No" rules the single woman; "yes" rules the married woman.

Socialization has built up an unfavorable image of man. The woman's relations with him are based on negation, defense, and caution until marriage. Marriage opens the doors to the exercise of sexuality, but the woman has already had enough time to internalize an unfavorable image of sex and the male.

Access to conjugal sex is seen as dramatic for women who must then abandon the model they were taught and acquiesce to practices previously forbidden: touching, kissing, going to bed, coitus. Women who until then had considered marriage to be the provision of domestic services find they have a duty to provide sexual services as well.

Tales of terror, running away, and pain on confronting genitality and coitus are part of the histories of the women who are now over 50. Women socialized in prohibition and with an internalized image of male evil are less likely to approach sexual activity as pleasurable.

A relationship with a man follows certain rules—deference to his will during the day is followed by submission at night. "You had to do what he wanted;" "My mother told me to do whatever my husband wanted;" Usually, this wasn't much. The practices surrounding coitus are of hiding the body; the sexual act does not imply complete nakedness, only uncovering the genitals. The lights are out; it is an attempt to hide. Women prefer it that way, since it is considered shameful to be naked or to look at naked bodies.

They agree that ignorance about what happens between the sexes had a negative impact on their experience of sexuality. More information and a less prohibitive attitude would surely have made their sexual experiences less painful.

Religious Morality and Socialization in Sexuality

Coming as they do from very Catholic homes, religious morality permeates these women's values about sexuality. The foundation for prohibiting sexual activity has its roots in their religious training.

We have already spoken of the values that express the "Virgin Mary" model of the woman of the time. The idea of sin is imprinted on practices associated with sexuality. Three terms are inseparably linked: sexuality = prohibition = sin.

All religions, not just the Catholic, "have profound influences on the development of individuals as sexual beings. . . . The ethical and religious ideas of believers are usually the major source of their human values. . . ."

Religion and morality demand that the values of fidelity, purity, and chastity be internalized. Women live in accordance with their religious precepts even in marriage.

Widowed women chose to remain faithful to the men they had married, and those who still had spouses could not fathom infidelity in their lives. The commandment to be faithful and its practice are tied to religious values and are culturally strengthened through the children: "They didn't want another father" was the case for the widowed women. The subject of sexual experience in widowhood will be addressed again further on.

Sexuality is what happens in marriage and women are completely ignorant of it until then. However, some women said that they were not so innocent; in "dangerous" situations, religious morality acts as a strong force to contain sexual desire. "If it hadn't been for the moral principles I was taught, who knows what would have happened, because there were certainly opportunities."

For widows, religious morality continues to be the force that gives them the strength to resist temptation.

Socialization was marked by two fundamental fears: fear of God and fear of humanity. Religion was experienced not as a liberating universal vision but, on the contrary, as oppressive and opposed to sexuality. Today the women recognize with certain sorrow the repressive character of their religious training. Piety and the practice of religion were obligatory and were enforced by threats. Of the entire group, only one woman revealed, in private, that she had had a man other than her husband after she was separated; another woman lived in free union with a man for some years. The rigid practice of religious morality and the fact that this guides their sexual conduct makes women feel some superiority regarding the sexual practices of today's young women. At the same time, as I have already pointed out, they agree on its punitive nature. Their testimony clearly reveals that religion contributed to the formation of a poor concept of sexuality. Religious commandments strongly influenced the sexual conduct of these women. Religious influence also colored their attitudes about the contraceptive practices that were available in our country in the 1960s when these women were in their fertile years, and resulted in their remaining married even though they were often unhappy. Most of the women in the group were submissive and resigned to their marital life.

I have already pointed out that only one of the married women later became separated. The others remained married until they became widows, and they have stayed as widows since. The precept that a marriage may not be undone is maintained by the weight that family tradition grants to religious commandments. For their daughters who have marital problems, mothers recommend resignation and fortitude. The number of children and the impossibility of earning a living further reinforce continuing the marriage.

This religion experience did not bring a liberating message; rather, it was a fearful experience that fed the submission to marital authority. Separation and divorce remain outside everyday life. In moments of intolerance, resignation gives one strength not to break up the marriage. Conditions do not permit female self-reliance—it would be difficult to expect it, given women's lack of economic independence and education, their many children, and the religious commandments that guide female behavior.

Some of the women even recounted situations of frequent mistreatment and alcohol abuse on the part of their husbands. Twenty percent of them stated that their marital life was surrounded by violence, loss of freedom, suffering, and male authoritarianism.

The Priest—Privileged Speaker

The socialization of sexuality is, above all, a question of attitude. None of the women remembered any conversation meant to inform about sexuality; they found themselves confronting sexuality when biological changes occurred and when they had engaged in sex in married life. The mother, who was in charge of the socialization, set an example but never spoke of such things; she found it so difficult to speak to her daughters about sex that she delegated the matter to the parish priest. The priest basically recommended deference to male sexual demands.

The young engaged couple would "go to pray" or to "publish the banns," and in the confession would ask for advice to clarify their doubts. The women found in the priest a man willing to listen to them and to give them moral counsel. Perhaps unlike today's youth, where there may be a great gap between religious beliefs and sexual practices, these older women experienced a consistency between religious morality and sexual conduct.

The priest is asked about family planning, about correcting certain uses and practices, about what to do in the face of marital conflicts, etc. In the confessional there is a more explicit conversation about sexuality—the priest knows the bedroom secrets, the desires and practices of his parishioners. He is the one who permits, forbids, legitimizes, advises. The priest synthesizes moral thought, and in that sense he is the teacher, the guide to moral conduct.

Sexual socialization is carried out in several ways:

- its prohibition is learned from maternal exhortation;
- its attitude is set by maternal example; and
- its moral and religious concept comes from the confessional and the priest.

Through all of these the "Virgin Mary" model for women is disseminated. This model is based on turning ignorance and the denial of a woman's exercise of her sexuality into virtues.

On the Body and its Functions

Our position rests on the hypothesis that the body is a mirror of social relations. The dominant sexual order regulates the social uses of the body, how each person carries his body, and how each one perceives his own body.

Thus conceived, the body is not only an anatomical and physiological reality, but also a space in which and through which social practices are carried out. The body's functions are played out in the context of cultural spaces that, in turn, imprint them with certain connotations.

Menopause, procreation, and menstruation are biological events that occur in specific cultural contexts. Each community, each people, has a set of norms, customs, values, rites, beliefs, and traditions that explain and indicate what is permissible and that attribute values to these social events.

Where do Babies Come From?

The concept of maternity, when it includes both the bearing and the raising of children, is one of the key values for the cultural archetype of what constitutes a woman. Although women, in the course of their socialization, are brought up to fulfill their maternal roles, realities such as pregnancy and the sexual act do not form part of their cultural inheritance. It is only upon entering marriage that sexuality and reproduction, and direct knowledge of them, are revealed.

Where do babies come from? "The Virgin brings them in a little basket;" "They're born through the navel;" "A woman (the midwife) came to the house and then my mother had a baby."

Reproduction seems to be unrelated to sexuality, at least until marriage. Children burst into life from somewhere outside. Women believe in an asexual maternity unrelated to the sexual act. During childhood, women do not know where babies come from, even though they are trained to raise them. They recall their mothers' pregnancies with difficulty. Their mothers wore dresses that hid their pregnancies and when asked where babies came from, they quickly answered that the Virgin handed them out.

The women considered the fact that human reproduction problems are now broached in formal education as an important advance. They consider this as a positive element in their children's education, even though they themselves still find it very difficult to explain human reproduction. Hampered by their own training and their meager education, they are thankful that the school fulfills the information function.

Menstruation and the Menopause

With the exception of four women (4% of the total), most of the group's experience with menstruation had been dramatic. They all agreed that they were totally ignorant about menstruation; they were never informed. One day, their first menstruation took them by surprise. They associated the menarche with a wound, a blow; many thought they had "burst inside," and they dared not tell anyone what had happened. The event was explained in terms of "It's what happens to women every month." Menstruation was not expressly associated with the beginning of the woman's reproductive age, though from that time on, the prohibitions regarding men became stronger, since "the dangerous age" had begun. It was forbidden to talk to boys, go out alone, have a boyfriend, and so on. Menstruation was unpleasant; dietary and behavioral proscriptions were imposed.

Information about menstruation was given after the menarche: only one woman said the information had come from her mother; for the others, it came from a relative—an older sister, sister-in-law, or friend. The mothers cautioned their daughters against the "danger to be faced once menstruation began—man, impregnator of chaste women."

In my opinion, the incorrect information received by the women in the group was not so much a result of the low level of schooling as much as of a rampant ignorance about the body and the belief in the concept of an angelical, asexual body.

The few women who had received some information experienced the onset of the menarche in a normal manner.

As a result of all this, the absence of menstruation—menopause—was experienced with joy by 60% of the women. It represented peace of mind and better health, opposite qualities to those associated with menstruation. The rest of the women expressed sadness, though in many cases it is not clear why. Menopause was associated with illness, the end of procreation, and the beginning of aging. Only one woman said that the relation with her spouse had become more satisfactory after menopause.

Thus it seems that neither menarche nor menopause are immediately linked with procreation. The former is experienced painfully and associated with colic, aches, and discomfort; its absence is experienced with joy, in that it means better health. The joy is not related so much to the disappearance of potential pregnancy as to the absence of illness.

In my opinion, the negative view, and particularly the incorrect information, regarding the menarche and menstruation help make them painful experiences for women. And menopause is not only a biological event; it is also usually experienced negatively by women.

To Love Again

Faced with the possibility of falling in love again, there are several groups:

The Widows

Love is linked to matrimony. They will not remarry because their children watch over their bodies and their sexuality ("What will my children say?"); because they fear their children's rejection if they try to enter into a new union; because they fear their family's mockery. They view themselves as having little or no freedom to make choices about their body and their sexuality; others decide for them.

Self-negation. As a result of the social negative—"We aren't any good for that anymore;" "You can't behave foolishly at this age"—sexuality is experienced as something that belongs to another time, to youth. When one is a widow and old, the social ban on love for the other sex and for sexuality becomes stronger. "That's not something for us. It would be vulgar."

Fear of another's opportunism. Economic considerations directly affect emotional relationships. Women will not begin a new relationship if they foresee many hardships and in a previous union they have had to make many sacrifices.

Fear of losing what they own. "He's after my house or my pension." The man is considered to be motivated by his wish to take advantage of the widow who has a little money. They believe that a mate will surely bring them to ruin or endanger their meager budgets. "Men are after their own interests. They don't marry you for love but for material things." The fear of being dispossessed is alluded to when the possibility of a new love is brought up.

Fear of losing freedom and independence. This is true for single and widowed women, especially when widowhood has meant the end of a union that involved economic and emotional deprivation.

It is not that sexuality does not exist for older people. Some of the women admit to desire; however, the weight of their religious formation, which equates desire with temptation and sin, and the social designation of the older woman as asexual is so strong that the older woman will always find an "excuse" to refuse new sexual relations or to stop being sexually active during her old age.

The fear of sexuality. This product of her negative and prohibitive socialization inhibits the establishment of new emotional relationships with men.

The Married Women

The married women operate from a sex-obligation-duty standpoint. Sexual activity is seen as a reward for the husband's goodness or something to be done out of fear that he will look for someone else.

The Single Women

Among single women there were several explanations for remaining unmarried: by choice, by destiny ("Even if I wanted to get married, God didn't create me for that"), or out of a fear of sexuality; those who would get married would do it more for companionship than for sexual need.

Two concerns are an obstacle to falling in love: the labelling of everything related to sexuality as vulgar and the social consideration that denies older women their sexuality and strengthens their fear. "An old person can't think about such foolishness anymore."

Although in some cases there is a recognition of desire, the weight of prejudice is usually stronger. This contradiction is resolved with recourse to religious morality: "God gives me strength to withstand temptation."

TOWARDS AN ALTERNATIVE PROPOSAL FOR THE STUDY OF SEXUALITY AND AGING

I have maintained that the family is the socializing force *par excellence* in sexuality. For this reason, I believe that activities aimed at resocializing or questioning the dominant sexual order must be directed at the family. These activities should propose new attitudes about those norms and behaviors that lead to a negative experience of sexuality and make it possible for it to be thought of in terms of communication, affection, and pleasure.

The educational proposal must lead to a reinterpretation of each woman's personal history, so that she comes to discover the meaning of the social distribution of the roles and parts assigned to the two sexes, the power relations that are established based on this distribution, and the set of values that make them cohesive and that are opposed to female independence and self-reliance.

We are not trying to impose a new model of sexual relations; rather, we want to offer elements that can serve to reflect on the experience of sexuality, to discover how and why a negative and distorted view of sexual functions was built, and which elements still inhibit sexual expression.

Neither do we intend to impose our own morality; instead we would like to offer the opportunity to reevaluate norms and moral values on which sexual conduct has been based so these can be placed in their historical context.

A norm should respect each individual's value system, thus creating an alternative, liberating vision of sexuality based on the conviction that people—regardless of their age, social status, or education—have a continuous capacity to change and to enrich their knowledge of themselves and of their relations with others.

The study of human sexuality will be approached scientifically, not morally. It will seek the bases of sexual conduct, which, of course, may be determined by morality. We will strive to be aware of our own conclusions or prejudices; there will be no value judgments. No moral judgment will be cast on any type of sexuality.

Meetings with older women will help strengthen those elements that may help to revise attitudes and behaviors that do not favor personal growth and communication with others.

The study will focus on recognizing the need to express affection in old age and on questioning personal and social attitudes that undervalue that need.

By approaching sexuality as a means to communicate affection and hostility, we will be able to extend its vision beyond coitus, beyond genitality. As a form of relationship between the sexes, it will enable us to understand the integral dynamic of the couple and their problems in aging.

Sexuality considered as a way of relating to the world, as a social relation, and as a subject of knowledge involves various disciplines: health, the social sciences, and the behavioral sciences. It should be the subject of an interdisciplinary approach.

A social perspective will allow us to confront the cultural determinants of sexuality and how these act on biological determinants, encouraging or discouraging sexual customs or behaviors. Prevailing social conceptions of sexual roles and body functions may distort sexual response or enhance relations with oneself and with others. In a social context, sexuality is not only a function or dysfunction of the reproductive system. It is, above all, a relationship between genders, the establishment of genders, and the exercise of practices based on gender which allow us to interact with another.

Sexuality is a component of health. There is a correlation between sexual ignorance and sexual problems, problems in health, and with quality of life. Sexual health implies a balanced interaction among the somatic, the emotional, and the social in such a manner that this multiple relation leads to personal enrichment, communication with others, and growth.

Although socialization in sexuality is basically a matter of attitude, it is possible to formulate proposals and alternative views by creating opportunities for discussion where older women can participate in reflecting on aging and sexuality.

Education about old age cannot be delayed until preretirement years or to 50 or 60 years of age. Education in independence and self-reliance should be ongoing; independence should be a way of life.

Recommendations

Health institutions should include in the concept of self-care and health a component on sexuality as basic to well-being. In this way, they will be able to facilitate the formation of trained personnel to inform, advise, and educate different groups of people about sexuality according to their particular health conditions. Topics could include sexuality and gestation; sexuality in regard to specific pathologies such as diabetes, hypertension, or disability; sexuality and retirement; sexuality and mental illness. They will create appropriate places to approach the problem of sexuality at the level of health personnel and users.

Health institutions also should promote the establishment of psychosocial support networks as forums for the discussion of emotional and sexual needs, to generate solidarity and support among their members, and to encourage the participation of the family group whenever possible.

Considering the growing number of older women who are widowed, separated, and living alone, and who experience their loneliness as a problem, it is important to promote the development of emotional support units outside the family, in order to share homes or common interests and to support cooperative self-reliance.

The creation of groups or organizations of older women which can discuss and collectively approach their aging process should be promoted, and they should seek to modify and recreate the self-image and social perception of the older woman.

Interdisciplinary work teams from the health and psychosocial fields should be established to comprehensively confront the problem of aging, and at the same time to include the discussion of sexuality as a matter of vital importance in training programs for professionals in health, in the human and social sciences, and in all programs of preparation for old age.

The establishment of self-reliant organizations and groups which can undertake projects or common interests (volunteers, women's leagues for community health work, groups for recreation, sewing, discussion, etc.) should be encouraged in order to strengthen the image of women as self-reliant and independent; these will also permit the development of emotional ties outside the family unit.

Intra-generational activities or meetings are also important. These can confront different views of life and sexuality and can make possible the establishment of centers where losses due to death or disability can be faced.

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Economic Aspects

PROBLEMS OF DATA COLLECTION AND RESEARCH ON MIDLIFE AND OLDER WOMEN

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INTRODUCTION

Economic development oriented toward women should be seen as a process aimed at expanding the capabilities of people—to live longer, to work longer, to have their basic requirements met, to be well nourished, to be healthy and literate, to live in dignity and self-respect, to be self-reliant.

Any developmental approach that places people, both men and women, first, must consider that the average age of the population in developing countries is low. In 1980, 39% of the population in developing countries was under the age of 15, as compared to 23% in developed countries. Only 4% of the population in developing countries was older than 65 years of age, while the percentage in developed countries amounted to 12%. These and other similar figures usually are interpreted to mean that the problem of the aging is negligible for developing countries, and, therefore, they should concentrate on problems facing the young. However, if we take a closer look, such an oversimplification far from reflects the real situation. Namely, in developing countries, data on aging should be linked with data on life expectancy to get a more accurate picture. By the middle of this century, in many developing countries life expectancy at birth was 30-40 years. Today, for countries which have available data (e.g., China, Sri Lanka, Chile, and Argentina), it is 70 or more for the female population.

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One of the major tasks of the United Nations' family of organizations is to monitor emerging trends. The United Nations' population projections foresee that by the year 2025 nearly 1.2 billion people will be in the 60 and older age group. *The population of the elderly living in the developing world will reach 71% of the total.* The emerging trend of increase in longevity in many developing countries is here to stay, even manifesting itself in the multifold increase of persons over the age of 80. This trend, reinforced by biological sciences which indicate that the projected life expectancy could be 120 years and over, points to the new social and economic importance of the third age for both developed and developing countries. This calls for an increased North-South partnership to collect relevant data and reexamine current concepts on aging in order to launch activities which would determine the position of the elderly in the twenty-first century.

The overall greying of nations did not bypass Latin America. A fourfold jump is projected for those aged 60 or over, i.e., from 23.3 million in 1980 to 93.3 million in 2025. The decreases in birth rates and some increases in longevity have changed the age structure of the Latin American population. As far as the female population of the Latin American continent, three age groups could be clearly distinguished: the group of young ("school") age up to 19 years, the group of medium ("working") age from 20 to 59, and the group from 60 years and older.

Applying these criteria, and using the results of INSTRAW-sponsored research, the Economic Commission for Latin America and the Caribbean grouped the countries into four major categories according to age of population:

- Countries with an elevated young-age female population, and relatively low proportions of the other two groups: Bolivia, Guatemala, Honduras, and Nicaragua.
- Countries with an elevated young-age population, and a relatively higher share of the other two groups: Ecuador, El Salvador, Haiti, Paraguay, and Peru.
- Countries with a relatively older population in which young and middle ages prevail: Brazil, Colombia, Costa Rica, Mexico, and Panama.
- Countries with an old population in which the group older than 60 was about 10% in 1980: Argentina, Chile, Cuba, and Uruguay.

Consequently, in Argentina, Brazil, Colombia, Mexico (the largest in population) and in Cuba, Chile, and Uruguay women older than 60 represent a social group of great importance now and in the near future.

It is obvious, as has been emphasized many times during the United Nations Decade for Women, that this old-age segment of women requires society's special attention. Old women are often solitary, abandoned, and even without access to the most basic needs. It is, therefore, necessary to collect reliable data on their living conditions in order to elaborate economic and social policy for improving their situation, as stipulated by the Nairobi Forward Looking Strategies for the Advancement of Women by the Year 2000.

PROBLEMS OF COMPILING AVAILABLE STATISTICAL DATA ON MIDLIFE AND OLDER WOMEN

Following the request and funding from the American Association of Retired Persons (AARP), INSTRAW has compiled an international data base on women at midlife and older in Latin America and the Caribbean. The main objective was to gather statistics and calculate selected indicators on elderly women beyond the age of 45 or 49 on 10 selected variables. At the outset of this research, it was clear that data were not available for the desired variables, so the research was carried out on the basis of a much reduced list from what AARP thought would give a comprehensive insight on the actual role of women at midlife and older and their participation and needs in development.

The data base attempts to present data on educational attainment, economic activity, marital status, etc., at three levels of disaggregation—by sex, age, and rural-urban residence, and for three points in time between 1950 and 1980 and the year 2000, where projections are available.[2] Not surprisingly, the statistics on corresponding indicators are more complete when the bases of the compilation are population projection estimates. These estimates are available consistently for 1980 and 2000—in the data base for males and females disaggregated on five-year age groups from 0-4 through 75-79 years, with an open interval 80 plus and classified by urban and rural residence. Though the projection estimates have more detailed age breakdown for women at midlife (45 or 49 through 74 years of age), there is very little information pertaining to older women (74 plus). The data obtained from national published sources are more limited, since for many countries in the Latin American region there is no age breakdown beyond 74. Clearly, this does not allow studying differentials in the situation of women of older age groups—who are more vulnerable to economic and health-related pressures and require direct policy intervention. Without entering into detailed analyses of data presented, I would like to point out some findings related to the economic role of elderly women.

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[2] The data base included the following:

1. Population distribution: Years 1950–1980; projections till 2000
2. Economically active population: 1980; projections–2000
3. Population engaged in agriculture: 1980
4. Educational level: 1950–1980
5. Marital status: 1980
6. Average number of children per woman and average number of surviving children: 1980
7. Rates of participation in the informal sector, including own account workers and unpaid family workers.

Data on **educational attainment** of the male and female populations, which indicate their preparation for the labor market, are available by age groups and classified by rural and urban residence. Due to difficulties in obtaining information pertaining to the 1950s, much of the statistics in the data base cover the period immediately prior or immediately following this period, up to and including 1980. Relatively few countries publish data in disaggregated form for those older than 70 years. In several of the countries presented in the data base, the type of education attained is presented by five-year (in some cases 10-year) age groups up to age 64 years, and aggregated for the 65-plus group.

The data on **economic activity status** of women and the sector of their employment indicate the number of aging women in the labor force, their participation in agriculture, and the proportion employed in the informal sector. For many of the countries in the data base, data are available on the activity status of women at midlife and older. However, as is the case with educational attainment, data on economically active populations classified by sex and by rural or urban residence are presented by five-year age groups generally between ages 15 to 74 and aggregated beyond age 75 years, and mainly cover the 1980s.

The second type of statistics on economic activity available in the data base are projection estimates of the male and female participation rates. For the Latin American and Caribbean countries, these data are also available for five-year age groups from 10-14 through 75-79 and 80 plus, classified by rural and urban residence. Data on economic activity in agriculture are not classified by urban and rural residence; with few exceptions, the age breakdowns are generally limited to up to age 75 years, and mainly for the period around 1980, as is the case with other economic activity statistics.

The difficulties in obtaining exact information on the dimension and predominant participation female population in the informal sectors of economy are well known and widely acknowledged. This data base project was no exception. As there was hardly any information on the economic activity within the sector, a proxy variable was defined, and statistics compiled separately on the "own account" and "unpaid family workers." These classifications of economically active population were not available for several of the countries, even for those for which activity status and employment in agriculture are available. In a number of countries the information was available in aggregates, without age breakdown. Gaps in the data base in the differential coverage of variables are significant factors limiting more extensive use of the available statistics.

Information on household income by major areas of expenditure presented by sex of the household head would give a more direct measure of women's household economic responsibility. However, disaggregated information related to income within the household is not available in the nationally published sources.

In broad terms, there is some information relating to the demographic situation of women at midlife, to older women, and to their level of economic participation. There is not enough information to analyze the economic situation and financial security of elderly women.

A synopsis of the conceptual problems encountered in developing the data base are presented in the paper submitted by INSTRAW to this meeting. I will briefly touch on some of the major problems.

CONCEPTUAL PROBLEMS OF STATISTICAL DATA GATHERING ON MIDLIFE AND OLDER WOMEN

There is greater international comparability in the information collected by the censuses since the 1970s, inasmuch as the countries in the area have incorporated the recommendations of the World Census Program of 1960, the Principles and Recommendations relative to the Population Censuses of 1970, and the Principles and Recommendations for the Population and Household Censuses of 1980.

However, despite the increasing tendency of countries to adopt these recommendations, lack of homogeneity of the information relative to some specific variables remains. For example, in spite of the recommendation to conduct censuses during those years ending in zero or one, or at dates as close to these as possible, often legal, administrative, or other obstacles prevent strict adherence to this.

Another difficulty arises from the differences of the definitions used, some of which do not always conform to international recommendations. In this respect, one of the more relevant problems is the existing differences in the conceptualization of rural and urban areas. Some countries follow political-administrative criteria, while others define urban and rural according to the size of the population centers. A third group of countries qualifies this concept by taking the type of defined infrastructure to differentiate the urban areas from the rural areas.

When focusing on the situation of women, clear limitations of the censuses are apparent in the coverage of certain more relevant variables. This is the case of the information referring to women's participation in economic activity. Though there is still need to call for sex-disaggregated data, there is admittedly more readily available information on male-female categorization. But there are additional difficulties in the way the information collected is published. Not only are data not always adequately separated by sex, but also the age breakdowns and classifications between urban and rural are often inadequate. To obtain this fairly straightforward cross tabulation, the raw information needs to be accessed.

As a kind of general conclusion three major points clearly emerge:

- The interchange and interaction between producers of statistics (statistical offices) and users (policy makers in governmental and non-governmental institutions) is generally not well established.
- The resources devoted to collecting, analyzing, and disseminating statistics and data on women in general and elderly women in particular are not sufficient.
- The need to improve the conceptual framework which will serve as basis for statistical data collection is critical. It is imperative to start now in order to secure availability of data for wide use by the end of this century and the next one.

The notions of statistics should be thoroughly changed. We should look on statistics as an essential tool for policy decisions. The statistical data base collected point to a wide range of different data that should be collected in the future. To make it happen we first have to strengthen research activities aimed at systematic data gathering on the third age.

BUILDING DATA BASES: AN AGENDA FOR FUTURE ACTION

Considering the significance and complexity of the questions of aging, it is most important to link these questions to the design and implementation of developmental policies at all levels. We have heard similar statements on many occasions, and undoubtedly there is a political will to do so. But questions remain about how to do it for the elderly in general and for elderly Latin American and Caribbean women in particular.

We have seen the kind of data we have at this stage—they merely point out emerging demographic trends. As stated in the recommendation of the study prepared for this meeting, we need statistics and data to devise policies which would foresee the possible impact of aging population on our economies; we need data which would measure the impact of development policies on the elderly; we need data which would measure the contribution of the elderly to development or their cost to society.

To resolve these and similar questions, an ambitious research program must be launched in order to provide a methodological foundation for statistical and data collection at national and regional levels. In short, statistical offices, demographic centers, and other relevant organizations should be provided with new concepts on aging and aging women, so that the data gathering could become an integral part of the ongoing statistical activities such as censuses, household surveys, time-use studies, and other data-collection methods. Improving concepts and methods for statistics and indicators on the situation of elderly women, which would lend themselves to international comparisons, would secure the flow of relevant, timely, and reliable data required by national policy makers and organizations interested in the problems of the elderly.

The new conceptual framework should encompass the following major clusters of data, which range from more traditional to more innovative ones.

- Data on **health care and nutrition** are crucial for maintaining and renewing the working capacities for day-to-day functioning of aging women. In data collection attention should focus not only on data on curative health services for fully dependent elderly, such as medical treatment of grave chronic diseases, terminal care of the dying, etc. Full attention should be given to data on preventive medicine and health services. The ultimate objective of such data is to show that active cooperation and participation of the aged themselves, their families, communities, and medical personnel can bring about the desired results of longevity and social contribution the elderly expect. Women's active role in securing adequate nutrition and raising levels of nutrition and hygiene is particularly important for such data collection.
- It is necessary to collect relevant data on **social welfare services**, including institutionalized and noninstitutionalized services provided by governmental and nongovernmental organizations as well as self-

help schemes. But data bases are necessary for the timely detection and registration of cases of endangered elderly women, particularly those living in rural areas. Data on social welfare service could also provide the basis for programming and for a more coordinated development of specialized networks dealing with the problems of the elderly. The ultimate objective would be to enlarge the established structures of social and gerontological institutions, which most frequently deal with the problem of the third age.

- Existing data on **environment and housing** should include the problems of elderly women in order to assess the needs of the elderly within the general policy related to environment and human settlements. The kind of environment suitable for elderly people has been described in literature and in plans of action. Well-presented data would provide a basis for devising simplified procedures for favorable credit arrangements, subsidized housing, or grass roots initiatives for providing low-cost family housing, including quarters for elderly women. Pooling funds and expertise could provide some innovative solutions to this enormous problem.
- A review of existing **pension and insurance systems** should be made available to facilitate the search for new solutions encompassing aging women in rural and urban areas who were not included in the "regular workforce" that makes them eligible for retirement benefits.
- Linked to the item above, is the need to collect data on **employment, work, and personal income levels.** Considering the current limitations in the active working life, research needs to be urgently undertaken to find the opportunities for retired elderly women to transform their professional activities into productive and socially needed work. Such work should be tailored to social interests and needs and to the women's respective abilities. In the Latin American context, the question is even more complex, since we have to address the needs of the poorest of the poor—women who have labored all their lives in the informal sectors of economy.

Solutions for work and professional activities of retired women and other elderly people should be linked to services, occasional and seasonal engagements (catering, tourism, child-care, etc.), and voluntary professional, humanitarian, and social work.

Another great challenge, especially for elderly women in Latin America, is to assess **personal incomes** in order to bring them in line with the covering of their basic needs which would be in line at least with the overall average living conditions of the population.

Data bases which would list and describe different environments along with well-identified solutions for the gradual transition from active life into new working endeavors are particularly needed at this stage. Namely, there are some new initiatives that are being launched to secure education and training for beginning a new life in the third age which should be evaluated and widely disseminated.

- Data on **family protection and social support for extended families** are particularly important for solving elderly women's problems in Latin America and the Caribbean. Families with elderly members should be taken into account when providing appropriate benefits such as tax benefits, assistance for agricultural activities, humanitarian assistance, etc.

  It is important to stress the moral and legal obligations of relatives to provide assistance to those elderly women in need. This means that research should provide methodological approaches for assessing intergenerational relations. Such data could strengthen some recent efforts to promote awareness of reciprocal usefulness of all ages and would avoid the cotting-up of old-age ghettos.
- Data on **participation in political life, professional associations, and community-level associations** could further foster recently awakened political abilities of the third age. The elderly increasingly could find ways to participate politically and socially. While old-age wisdom is respected in most developing societies it generally does not apply to third-age women. Aging women should be adequately represented in all relevant political and societal organizations and authorities such as parliaments, trade unions, local community councils, etc.

  Data on political participation also should include a review of existing legislation in order to promote the changes needed to benefit elderly women.
- The rich body of data related to **education and culture** is mostly limited to younger segments of the population. Elderly women's work potential and experience can be significantly supported by providing them with access to educational and training facilities. It also could be useful to get data on their participation in cultural activities such as singing in choirs, drama, painting, sculpture, literature, preservation of cultural heritage, etc. It is important to note that future oriented data on education for the third age should be supported by means of public communication and information.

To conclude, the list of statistical and other data which would be needed for policy formulation to secure elderly women's well-being and participation in development is far from being exhausted. Regarding population data and population policy it is of the utmost importance to improve statistical data gathering which would reflect emerging trends that point to the significance of third-age women in Latin America.

Those data are an essential prerequisite for regular analyses and monitoring of aging population patterns and growth, including the processes of depopulation particularly in rural and migrant areas. This also includes the monitoring of the distribution of the aging population and aging women to promote new developmental activities suited to this age group.

Finally, the problems of aging and third-age women, as any other economic and social problem of the contemporary world, cannot be resolved without changing current developmental approaches. Efforts on behalf of elderly women in Latin America and the Caribbean, supported by elderly activists in the developed world, should contribute to the desired changes by starting a concerted international effort to gather data.

It is now clear that we should revitalize data gathering in order to revitalize the perceptions about the third age.

The United Nations began the process by convening the World Assembly on Aging in 1982. Follow-up activities will depend on strengthening the networking among the existing institutions devoted to the third age, and on the expansion of these networks by including relevant developmental organizations.

At this stage, the role of research cannot be emphasized enough. The Household-Gender and Age program launched by the United Nations University, with the modest cooperation of INSTRAW, is a case in point. The other cosponsor of this meeting, the United Nations Center for Social and Humanitarian Affairs, and the newly formed United Nations International Institute on Aging should lead in this area and cooperate with national institutions that have an international scope.

INSTRAW is ready to contribute its experience on methodological approaches for compiling statistics, indicators, and data on women, on how to change the existing concepts, and how to launch the new ones, particularly those related to women's work and income in the informal sectors of economy. We also can share our experience on how to join forces around well-defined common tasks for generating more statistics, more indicators, and more data on elderly women.

The "grey revolution" is an increasingly visible phenomenon in both developed and developing countries. The growing political influence of third-age persons, particularly in the developed world, could help create a brighter future for the great majority of elderly who will live in developing countries by the year 2025. We should start building now in order to secure action that will lead to new perspectives and will secure human dignity to the third age and to the women who constitute its majority. This conference is another step in the right direction.

ROLE CHANGES IN THE MIDLIFE WOMAN 45–60 YEARS OF AGE IN COLOMBIA

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In Colombia, role changes in women at midlife (45–60 years of age) are closely tied to the rapid transformation which has taken place in the country's society and culture over the past three decades. These changes began with a massive urbanization: in 1938, 70.9% of Colombia's population lived in the countryside and 29.1% in cities; by 1985, only 34.7% lived in rural areas and 65.3% in urban. The urban population is concentrated in four main cities and a few mid-sized ones, and in all of them women constitute the majority of the population. Of the urban population, 8,927,542 are male and 9,786,011 are female; the same imbalance is found in large and mid-sized cities, a sign that women are particularly affected by the effects of urbanization which prompt them to make changes.

The women under study—the oldest of whom would have been born in 1928 and the youngest in 1943—experienced socialization in an institutionally rigid urban environment which could not adequately serve the growing wave of immigrants whose various regional subcultures helped create a cultural polymorphism. Today these are cities characterized by a lack of single models and objectives, a situation that creates a climate of harmony among the newly arrived and those born there. These women are subject to their influences which create new needs within a current of uneven transformation.

In the countryside, these women also have experienced changes caused by technological advances unevenly distributed in different geographic areas. Besides the demographic transformation in the community, there is also an economic transformation, as the country rapidly moves from a rural agrarian economy to an urban industrial and service-oriented economy. There is a strong dynamic of change confronting institutions: the economy, education, religion, politics, and the family, among others. When women in this age group are placed in the context of this process, two pictures clearly emerge: the traditional woman who remains within past structures, and the woman who assimilates new roles.

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The former is in charge of a home where she plays her role as an administrator of consumption, as a breeder and as a transmitter of culture, and as the creator of a fulfilling erotic-emotional atmosphere. Her stage for these roles is the home, where she lives as a dependent of, sharing the status of, and representing her mate, the home's sole provider.

The woman who is open to change, on the other hand, adopts new roles when she is exposed to changing events in her sociocultural milieu. The first she assumes when she joins the labor force, which converts her into a coprovider in her home. This innovation has several consequences, since it transforms structural elements of her patriarchal family and slowly alters roles within the family, eventually leading to changes in the household tasks that are emphatically assigned to the traditional woman and which are now satisfied in different ways according to the demands generated by the new economic role.

Our recent study in the patriarchal area of Santander enabled us to delineate the following stages in these role changes, which we have estimated quantitatively according to the homes and the type of women in them:

1. Traditional: Man is the sole provider and woman stays at home, approximately 60%.
2. Woman in transition: Man and woman are coproviders and woman solely responsible for household tasks, with role conflict, 15%.
3. Woman open to change: Man and woman coproviders and responsible for household tasks, 11%.
4. Role reversal: Man in household tasks and women as sole provider, 3%.
5. Woman in broken marriage: Woman sole provider and responsible for household and child-rearing tasks, 11%.

It should be noted that the last four stages made up a larger proportion when the women were younger and worked outside the home. It is well known that marital status is a determining factor in some female roles;

when marital status is altered, some roles are also changed, especially if ending the marriage significantly affects economic status, either positively or negatively. Simple observation reveals that a high proportion of unmarried women at midlife must currently assume the role of providers for themselves, contrary to the norm in traditional society. The changes in marital status affecting the group of women under consideration here, mean that an increasing number are divorced or separated, as will be shown further on; thus, they fall into the category of those who must look out for their own welfare as well as that of their dependents whenever the law does not grant them enough protection.

Proof of the above statement can be seen in figures from the 1985 census, according to which, of the female population between 45 and 59 years of age, who made up 6.84% of the nation's women 12 years of age and over, 2.1% were economically active; 2.06% were working; 0.01% were looking for work for the first time; and 0.03% had worked previously. The economically inactive population was 4.58%, more than double the economically active, and was distributed as follows: renters, 0.06%; retired, 0.1%; students, 0.07%; home, 3.89%; and no activity, 0.46%. No information was available for 0.16%, and there was an unemployment rate of 1.91%. Thus, the supposition that these women assume new tasks is valid, and it is accentuated in their search for productive work.

The participation of midlife women in new roles can be further elaborated by comparing their work situation with the educational level achieved. The proportion of the female population 45 to 59 years of age which was employed in the week preceding the 1985 census, according to educational level, was 2.96% in the capital, whereas in the rest (rural) it was 1.46%. Their status in the labor force can be inferred from the fact that, of women in the urban area, 0.44%[2] had no education, and in the country this figure reached 0.5%; 1.52% had completed primary school in the urban area and 0.75% in the country; 0.78% and 0.06%, respectively, had completed secondary school; university level was achieved by 0.15% in the city and 0.01% in the rural area.

From this correlation of education with work situation, the occupational level of the woman at midlife can be deduced. It must be kept in mind that the country opened its classrooms of higher education to women in a massive and qualitative form only around the middle of the century, and this had a greater influence in urban areas. In the 1951 census, 43.9% of women at midlife were illiterate, whereas the 1981 home survey showed that this total had declined to 21.8%, of which 14.3%

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[2] N = total number of women employed during the week preceding the 1985 census.

were in urban areas. Female cohorts older than this group did not generally enjoy the benefit of university education; they achieved mid-level education in limited numbers, generally earning teachers' certificates, a well-known option for women. However, younger age groups found that in their youth university classrooms were open to them in a limited way, constrained by cultural concepts that oriented their education according to values ascribed to women. This explains their majority position in the service occupations, if viewed according to a classification by job specialties, and as manual laborers, low-status employees, and only rarely as owners or directors, if viewed according to levels of employment.

Furthermore, female work is classified as unpaid assistant in the home, particularly for women at midlife who are still given shelter by small family-type enterprises characteristic of a certain period in urban development. The ethical and cultural obligation to carry a multiple workload in the workplace and at home, in addition to the marital patriarchal values that keep them from achieving responsible positions in the work force, reduce women at midlife to low-status work, especially those who today experience the transitional role stage referred to earlier. Unless they have support from institutions or the extended family, they must stop working for long periods during the child-rearing years, and they are unable to accrue enough work time for retirement benefits. When they are again ready to look for work, they find that their age works against them; their training, too, may be an obstacle since it is less than that of younger age groups who have been able to reach higher educational levels.[3]

These family obstacles also help explain how the woman undergoing role transitions is placed in low-level work and does not reach positions of responsibility. Work advancement is only possible in groups where there is marital collaboration to make gender roles within the family more equal. And women at midlife, in our experience, do not find themselves in these circumstances. Thus, they are concentrated in non-professional activities and their participation in upper-level positions is restricted.

The molding of women's image for traditional roles is also a factor in their subordinate position. For this reason, as already observed, they join the work force with limited educational preparation, which determines their work placement. The service sector uses them, particularly the domestic trades, conditioned to their cultural molding in the exercise of traditional tasks in the home. This economic sector, which today enlists women en masse, is the one that provides the least in social services. It is also the one which offers the least remuneration and the most demands in terms of the workday, yet in large cities it becomes the answer to the woman's urgent need to work. Younger age groups today avoid this sector, which is being filled, especially for day work, by lower-class urban women at midlife.

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[3] In 1985, 0.01% of women between 45 and 59 years of age had zero to three years of university education, and 0.02% had four years or more.

The previously described circumstances help prevent a woman between 45 and 60 from achieving a retirement pension, health and recreation benefits, and so on. Her position in the labor force sectors that do not recognize her, the irregular coverage of the time prescribed, or her late initiation into the work force at low levels further reduce these benefits. Up to the present time, only the youngest of the group of women at midlife can attain these social services. The rest are at the mercy of whatever support is offered by the extended family or their children.

But the Colombian family is currently undergoing an active transformation that keeps pace with a global institutional change. Internal structures are being transformed and their functions are changing in content and coverage. Women's work also has been at the heart of this dynamic. The multiple workday (at work and at home) and the urgency of her role as coprovider or as sole provider/part-time domestic, have shifted internal role mechanisms, gender images, and the status of each sex, and have transformed the man-woman relationship and modified their traditionally assigned territories.

The shift in functions is an outstanding part of the change, because reevaluations and adaptations to urban situations occur in new models. New types are also emerging which, although familiar in the lower sectors for a long time, are structures that are today invading the middle and upper sectors where they were previously unknown. I refer to consensual forms that are currently invading these social groups and to other modalities that come and go according to the need they fill. The trend toward the nuclear family which young people were adopting has again shifted toward the extended family and the combined family; this will be quantified further on. We also see modalities formed outside the law, and even those above it, in superimposed domestic units. Finally, the breakup of the family offers new alternatives in incomplete homes.

The context of the extended family is part of all family transformations, and it is here that women at midlife satisfy new roles. When the daughter's generation enters the labor force, the grandmother makes up for the lack of institutional support. The work in Santander showed this assignment of tasks in the Los Egos women, who cared for their grandchildren during the daughters' workday and took them home at the end of the day. In neighborhood groups some mothers created informal daycare centers where the young mothers who worked outside the home paid for child care. Women at midlife also have begun to form part of the management of the Welfare Homes *(Hogares de Bienestar)* that the Colombian Institute of Family Welfare is creating for urban lower class sectors in large and mid-size cities (though I could not quantify their statistical proportion).

The effects of the family break-up constitute one of the main catalysts to role change in women at midlife. Even traditional women's groups find they must escape from the traditional and optional family model at this age and prove themselves economically by entering the labor force.

Zamudio and Rubiano's study showed the incidence of different marital breakups for the generations born between 1925 and 1939 (Table 1). As can be observed, the process of breaking up and separating forces the woman to rely on herself or her children.

Today, this family modality has led to the phenomenon of the incomplete unit formed by the children and a single spouse, usually the woman. The incidence of these two types of homes in the country is shown in Table 2. Although it was not possible to exactly quantify the extent to which the woman at midlife participated economically in these homes, it was found that she was usually the one to assume the role of provider in the broken homes (77.1%), though she also did so in some complete families (1.0%).

In other words, many women at midlife had to assume economic roles to meet this obligation. If this situation is analyzed in the combined fam-

Table 1. Proportion of separated persons in each order of union, by generation and sex. Urban population.

	Men		Women		Total	
Generations	1st time	2nd time	1st time	2nd time	1st time	2nd time
1925–29	18.0	18.0	24.6	33.8	21.2	10.7
1930–34	17.2	11.7	24.6	66.7	22.2	30.4
1935–39	21.0	3.9	25.2	45.7	23.2	15.2

Table 2. Percentage of different types of families in complete and incomplete homes.

Family type	% Incomplete homes	% Complete homes
Nuclear	8.6	50.4
Extended	12.0	19.2
Combined	3.0	6.6
Total	23.6	76.2

ily, there are even more women who had to take on the male obligation as provider when the man is absent in incomplete homes. This means that, given the situation of marital breakup and the obligation the separated woman assumes as the provider for herself and her children, and the rebirth of these units in urban areas, there is no doubt about the obligation that the woman at midlife currently assumes in taking on new roles.

Successive family studies in Colombia, along with the one carried out recently in Santander, make it possible to confirm that female economic management in extended groups is predominantly in the hands of women at midlife, who particularly assume it in incomplete homes, as can be seen in the tables. These women take in elderly parents, and it is mostly the single women at midlife who assume this responsibility. When they marry, they enter the work force to support them or give them a home, feeling that their role as co-provider gives them the right to bring them into their home, as we found in Santander. In exchange, the parents take care of the grandchildren or do housework, thus compensating the effort of the daughter who gives them shelter in her new productive role. Of all the homes surveyed in Los Egos, 3.5% had an older parent who was supported by a woman between 45 and 60 years of age.

Finally, the retirement age of 60 for men has been lowered to 50 for women, as a state policy to benefit the woman at midlife. Little by little institutions emerge where they can work, but as yet they are limited in number, especially for the lower class sectors.

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WIDOWHOOD: THE SOCIAL AND ECONOMIC CONSEQUENCES

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Widowhood marks an important point in the life cycle of many older women and is a reality with which the majority of women in Jamaica can expect to contend in their old age. The reasons are that women tend to outlive their spouses (life expectancy was 72.6 years for women and 68.1 years for men in 1982), and that wives are typically younger than their husbands and therefore have a greater probability of outliving them. Consequently, there are more widows than widowers in Jamaican society, and the same holds true not only for Jamaica but for most developing and developed countries.

Jamaican widows represent a significant proportion of the population. One in eighteen (1 : 18) women 15 years and over is a widow. The proportion increases gradually, reaching 1 : 4 in the 60 years and over age group (Population Census of the Commonwealth Caribbean, 1982).

The literature on widowhood informs us that widows experience significant changes in their quality of life. Bahr and Harvey (1979) noted that widowhood presents serious personal adjustment and mental health problems, while Berardo (1969) observed that widowhood is significantly associated with bereavement and mortality.

This paper intends to show that Jamaican women over the age of 60 years suffer severe hardships socially and especially economically as widows. For the purpose of this paper a widow is defined as a woman whose husband has predeceased her.

The subject of widowhood has been a neglected one. Rawlins (1987) comments on this fact while noting a plethora of studies on the Caribbean family since the 1940s, as well as the availability of literature on women in the Caribbean since the Decade For Women (1975–1985). But the scarcity of data on widowhood is not restricted to the Caribbean. Schlesinger (1981) voices his concerns about the scarcity of data and information about widows and widowers in New Zealand.

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In our society, widowhood essentially affects elderly people (Table 1). The ratio of widows under 45 years of age to widows over 45 is 1 : 19, and 25.3% of all women over 60 years old are widowed (1982 census data). The average age at widowhood is 61 years—more than 11 years short of the average life expectancy for women.

METHODOLOGY

The data utilized for this paper arise from a study of 30 widows in Kingston, Jamaica. Twenty of these women were of working-class origin and communities, while 10 were women of the established middle class of Jamaican society. The study also utilized data available on the widowed population from the 1982 Jamaican census.

The first widows in the sample were identified by two prominent women, one in a working-class, low-income area and the other in a middle-class area. These widows then identified other widows. They were all interviewed in detail in order to compile case studies. Other widows were also identified in a survey by Rawlins (1988), which sought to explore the lives of middle-class women in Jamaica.

SOCIAL AND ECONOMIC CONSEQUENCES

Social Consequences

As was noted by Berardo (1969), widowhood produces a social vacuum in the life of the older woman which is difficult to fill. The social vacuum

Table 1. Number of widows in three age groups and total female population in the same age groups, Jamaica, 1982.

Age (years)	Widows	Total female population	Ratio of widows to other females
15–44	1,926	476,290	1 : 247
45–64	12,265	136,060	1 : 11
65 & over	23,453	80,891	1 : 3
Total	37,644	693,241	1 : 18

Source: 1982 Jamaica census data.

was most acutely felt by the Jamaican middle-class widows. For some, an active social life had been an important part of their *modus vivendi*. Important social functions for persons who were active members of the local economic elite, as their husbands had been, were now held without invitations being extended to these widows. Some noted that in the first year of widowhood these invitations continued to be extended, but gradually the numbers diminished until invitations ceased altogether.

The numbers of widowed women versus widowed men or other marriage-eligible men in the society are shown in Table 2. These statistics are important, as they indicate opportunities for remarriage and male companionship for widows. The available figures have been discussed (Rawlins, 1987); they show a smaller number of men than women in every age group (the proportion is 1:4 in the 60–64 age group). This ensures that many widows will not be able to find a new husband or other male companion, and thus have no choice about continuing their lives as single women.

The need for companionship was stressed by all the widows, but none of them had persisted in a state of despair over the loss of her husband. Most seemed to have overcome their grief after a relatively short time, but some asserted that "you never really get over the loss." Those whose bereavement was most prolonged were those who had been living alone with their spouse at the time of his death.

Among the problems mentioned by some widows was their fear of living alone, not because of the physical and emotional need for companionship but because they feared being preyed upon by burglars. (It is not uncommon for such women to become the target of local thieves.)

In Jamaica, women frequently defend having large families by stating that it is insurance for the future. The working-class widows, however, voiced opposite views, having experienced the reality of problems caused by large families. Some widows also expressed their thoughts on the advantages and disadvantages of having had children. In this regard, some stated that having children was no guarantee that one would have companionship or receive financial assistance from them in later years. Rob-

Table 2. Number of widowers and widows age 60 years and over in Jamaica, 1982.

Age (years)	Widows	Widowers	Total Females	Total Males
60–64	4,774	1,223	30,603	26,297
65 & over	23,453	7,793	80,891	67,996
Total	28,227	9,016	111,494	94,293

Source: Jamaica census data, 1982.

erts and Sinclair (1978, p. 304) note in their case studies the philosophical resignation of many women, who observed that some women have children who help them, while others have children who don't.

Economic Consequences

The loss of a husband creates many practical problems for the Jamaican widow. The car and house still need to be repaired; insurance and other expenses for house, car, and self are still required; and property taxes (for homeowners) and rent (for nonhomeowners) still need to be paid. In effect, most previous economic responsibilities remain, but the widow has lost the economic contribution of her partner.

The most serious concern the widows mentioned was that of supporting themselves. This concern was voiced both by women of lower socioeconomic background and those whose husband had been in the middle-income bracket, even if the widows had themselves been employed or were still employed.

Most of the women interviewed for this study were heads of households, and were expected to support themselves from the resources they had available to them. The working-class widows had not had recourse to life insurance held by their husband, and the middle-class women, for the most part, had received what appeared to be small sums of insurance money, in the range of J$16,000–J$20,000. In some cases, policies had matured prior to the spouse's death and the money had been used in his lifetime.

NATIONAL INSURANCE AND WIDOW'S BENEFITS

Because the economic consequences of widowhood are of such great significance, it is useful to discuss the benefits that are available to widowed persons in Jamaica.

The Jamaican Ministry of Social Security operates the National Insurance System. Included in its scheme of provisions is the widow's benefit.

Women become eligible for widow's benefit upon the death of (a) their husband, or (b) their partner in a common-law union.

To qualify for widow's benefit the widow must satisfy four specific conditions relating to her age, the duration of her marital union, and whether or not she has minor children. If a widow satisfied none of these conditions but was married for at least three years, she can receive a pension for one year. Some widows might not be eligible for widow's benefit but might be eligible for old age benefits, which are paid to any woman age 60 years or over who has made the required National Insurance contributions and has retired.

The pension issue was extremely vexing to some of the women. Even a retired government employee who had been fairly highly paid is not likely to get a pension much in excess of J$300 per month (compared to a take-home pay that might have been J$1,000 per month). Generally, pensions range from a high of about J$300 to a low of J$60 per month. Retired teachers receive pensions that are totally inadequate to meet their needs and that often do not even cover their monthly electricity bill.

CASE STUDIES

Two summarized case studies are presented below. They are intended to focus on some specifics of the social and economic circumstances typical of the widows interviewed.

Case No. 1

Mrs. R is 75 years old and has been widowed for 11 years. She said her husband had died "of a skin condition." They had been married for 30 years and had one child. He had worked as an agricultural laborer and she had worked as a nursemaid in the United States sporadically over an 11-year period.

Mrs. R lives in her own four-bedroom house; she receives a pension of J$40 per week and rents a part of her house. The rental and pension are important aspects of her financial maintenance. She had received a "lump sum" of money from her husband's employers on his passing (he had no life insurance).

She is a member of the Senior Citizens Association in her community, and she also helps to care for children of her relatives on a daily basis. She appears to be managing fairly well financially. For her the worst part of widowhood was having to do chores that had previously been done by her husband.

Case No. 2

Mrs. E is 61 years old and has been a widow for nine years. Her husband died of a heart attack at age 55. They had been married for 24 years and had 10 children that now ranged in age from 24 to 40 years. She is now retired, but had been employed by the local university as a laboratory attendant for 21 years.

She lives in her own house, for which she still owes the bank J$1,000. The house has eight bedrooms, but it is in a state of great disrepair. She is the head of her household and provides "shelter" for eight of her children, seven of whom are unemployed. These children altogether have 17 children of their own, nine of whom also live in Mrs. E's house. Other occupants of her house besides her children and grandchildren are one female tenant and her four children, three other children (nonrelatives), and the common-law husband of her youngest daughter. Thus, a total of 27 persons reside in Mrs. E's house.

Mrs. E's sources of income are a pension of J$40 per week and occasionally the rent from the tenant. Her children, she says, are of no help, as seven are unemployed and the others have their own families to support. She worries about the future: "Life is very hard and we struggle each day. If only I had some money I would fix up the house and rent out a bigger part."

She remarked that she did not "grieve for long" when her husband died, because she was still employed and "the people at work were especially good to me." She says that her involvement in the church was a comfort. The fact that her children depended on her for all sorts of support also helped her through her period of bereavement. She says that she misses her husband because the house is in a state of disrepair, which he would not have allowed if he were alive. She says she is in good health and passes her day by "minding" nine of her grandchildren, and sometimes some of the other children who live in her house.

DISCUSSION

The widows reported on in this paper had been married to men who were an average of six years older than themselves. The average age at widowhood was 61 years, and the average number of years of widowhood was nine. Family size for the working-class women was an average of five children born alive, and for the middle-class women, three.

The demographic data for Jamaica reveal that the population over 60 years old has been increasing steadily since 1970, from 8.4% in that year to 10.8% in 1982 (Department of Statistics, 1982, p. vii). The population age 65 and over increased from 100,875 in 1970 to 151,427 in 1982, with the majority (82,189, or 54%) being women (data from a social and economic survey done in Jamaica in 1984). This increase in the elderly population signals an increase in the number of widows, given the greater life expectancy of women.

The economic consequences of widowhood seemed pervasive, and this subject was raised in almost every contact with widowed women. These women mentioned numerous financial problems that they had not anticipated while their husband was alive. Some received no widow's pension or benefits, and some received no assistance from local relatives or friends since these people were unemployed or underemployed. In Jamaica general unemployment is 25%, and 40% of women are unemployed (data from an economic and social survey done in Jamaica in 1985).

Some Jamaican widows can expect to receive financial assistance from their children, but such aid is dependent on a number of factors. Evidence from the interviews (of which two-thirds were of essentially working-class persons) did not indicate a high incidence of financial assistance from relatives. Most were dependent on the meager widow's pension and their own initiative. Lopata (1978) in a study of 1,169 Chicago widows found that children were the only kin offering economic, social, or emotional support to widows, and even from them the support was relatively small. Her sample, however, was for the most part made up of individuals who were financially independent. In the Jamaican situation, in which there is often dire need and in which some widows cannot support themselves financially, we found little assistance.

Some widows mentioned their fear of illness, with the high cost of private health care and the interminable waiting-time for attention within the public health service. Another health-related concern noted by some women was that, after having played nurse to their husband prior to his death, they feared they would have no one to tend to them in the event they became chronically ill.

An additional problem faced by some widows was the need to care for elderly siblings, aged parents, or other relatives. One widow in this study, then 61 years old and still employed as a secretary, cared for her 30-year-old daughter who was incapacitated by a psychiatric illness. Another widow, at 63 years of age and also still employed, had sole responsibility for her 88-year-old mother.

In conclusion, perhaps the most important finding of this study was the lack of information on widowhood in Jamaica, which suggests that there is a lack of awareness of the social, economic, and psychological problems of widowhood. This points to the urgent need for research to be undertaken in this area. The universal references to economic problems highlight the widows' fears of their inability to support themselves in the future. Widows' benefits and old age pensions are grossly inadequate, given the high cost of living.

The inadequacy of the benefits available to widows is an indication that inadequate sums of money are contributed to those pools of funds during the work years. Perhaps more realistic payments to the National

Insurance and the pension fund during one's working life would provide more sufficient benefits in widowhood and old age. Additionally, organized discussions with women before they reach midlife on aging and some of its consequences should help them to prepare for eventualities such as widowhood.

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CHANGING GENDER HIERARCHIES BY COHORT IN A BRAZILIAN SUGAR PLANTATION

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This paper aims to analyze the changing social organization of households within a modernizing plantation society, and to verify if gender hierarchies typical of plantation households are carried over into this process. Comparisons are made between different cohorts of interviewed persons at different points in the plantation's history.

A household is defined as a residential unit where people live together over time and jointly perform different activities for the production and reproduction of the unit, the community, and the society (Masini, 1984, p. 1). A key aspect of households is the way in which genders and generations relate to one another. Bonds may be egalitarian or hierarchically organized. In the latter case, households are also characterized by a clear-cut sexual division of labor, which allocates, by gender, activities performed for generating income and the nonremunerated activities performed for the maintenance of the household.

Another important aspect which binds household members is the regulation of reproduction carried out through the control over women's sexuality and fertility. The control's form is itself important, since young women's courtship patterns before marriage may be controlled, whether or not the married women in the household have many pregnancies.

It is more difficult to follow the dominant group's prescribed norms of behavior regarding social contacts when women must work outside the house. In plantation life, when family labor prevails as a pattern, women perform work in the fields accompanied by their kin. The change from family work to individual labor contracts, which tends to occur when households move outside plantation boundaries, may shift the control over women's sexuality as contact with men outside the kinship network and neighborhood environment is facilitated.

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Another major change deals with the fact that fertility now may be controlled through contraceptives, and the control of courtship patterns may lose importance as a strategy for controlling reproduction. The older generation is more likely to have had more early pregnancies.

Since they are not isolated units but constitute part of a larger totality, households should be studied in the context of larger societal and political processes. Households in plantation societies constitute an important case study for social change. The position of the housing within society's productive apparatus is a key focus in the analysis of households. Throughout Brazilian history, the production relations which bind household workers to plantations have changed substantially—from slavery through household labor, to the current system in which workers are individually hired. Housing tends to be a central concern within a labor contract. Plantations have been modernized through changes in technology. A particularly interesting case is the study of the modernization of sugarcane production as a consequence of the massive production of alcohol as an alternative fuel for motor vehicles. The use of modernizing technology without major changes in the production relations has been identified as a conservative modernization process.

As I pointed out in a previous work (Aguiar, 1986), in analyzing household and work, one should consider the following possible situations: the residential unit as the unit of production; the residential unit as apart from the unit of production; the residential unit as contiguous with the unit of production; the residential unit within the production unit. Large landholdings that exploit commercial agricultural production, if they allocate residential units to the workers as part of the work contract, provide an important example of the relationship between housing and production. In this case the residential unit is contained in the production unit. In industrial capitalism, the transformation unit becomes differentiated from the residence and becomes the key unit of production. The social organization of the work which occurs within the residential unit makes it easier for some and harder for others to leave the housing environment to work in an enterprise or other unit of production outside the residence.

When residents of these large properties are expelled from the plantation, the residential unit separates from the production unit and new subsistence must be found. As workers, they buy, rent, or acquire housing and subsistence goods when space for planting, growing, or raising subsistence items is insufficient.

The control over domestic quarters is enforced through religious norms which establish an honor system. This honor code restricts women's contact with men, thereby also controlling men's sexual activity. The analysis of households through housing information reveals everyday activities which are hidden from view; major aspects of gender relations may be gleaned within the house (Barbieri, 1984).

Avoiding public contact with male strangers enhances household honor. Women's sexuality is controlled through this system, whereas men face no constraints about approaching women unaccompanied by their kin outside the household. Where these norms prevail, women may be sexually harassed by men in public.

The established sexual division of labor decrees that men are the major income earners and that women will look after household needs as housekeepers and child rearers. When exclusively dedicated to these activities women earn no income and so are dependent on those who bring income to the household. Gender hierarchies may be comparatively studied.

In the current study women are a central focus of our analysis of households.

HOUSING LOCATION

Housing stratification establishes the landowner's house in a position of control which allows it to oversee the domestic quarters (Gilberto Freyre, 1973, *passim*).

The house's interior and its position in its environment are major indicators of the status of a household within a social stratification system. Housing is an indicator of lifestyle, and it has even been used by students as a measure of social standing (Caplow, 1985). The large, main house symbolized the power of the landowners. Current archaeological studies of plantation life clearly reveal this pattern (Kelso, 1984; Singleton, 1985). Workers' houses were first grouped around the main house, which exerted social control. Later, slave quarters changed, and we find that workers who had a fixed residence within the plantation site also were under the vigilant supervision of the plantation managers.

The interviews were carried out in the house; all women 15 years old and older living in the house and who were either working or had at least one household coresident working in the plantation site were interviewed. To identify such houses a list of all houses surrounding the plantation area was obtained. Criteria for choosing the interviewees included finding at least one resident worker living in the house. There were several historical points for studying the position of the housing in relation to the plantation. The first one was the movement of the residents in the plantation towards housing built outside of the plantation site.

It was apparent during the interviews that, although plantation houses were large and better built than many other types of housing visited (many had internal bathrooms and were brick constructions), they were not well maintained; apparently, plantation owners and administrators had no plans to improve their condition. In one site, they were even falling apart.

Yet, ownership of these houses was still being disputed, as an old retired worker we interviewed mentioned: he was suing the plantation to try to get the title to the house where he lived and which belonged to the plantation. Having been a plantation resident had marked the lives of most of those we interviewed and their coresidents, and this factor provided a landmark for the current study.

A key question of this study has to do with finding out if housing which separates from the plantation becomes less patriarchal, with women becoming less segregated within the house as suggested by a few works (Ardender, 1980; Hayden, 1980).

CHANGES IN HOUSING ARRANGEMENTS AMONG PLANTATION WORKERS

The following paragraphs describe the village and squatter settlements from which the interviewed population was chosen for this research.

In 1959, the Société des Sucreries Brésiliennes, the French corporation which has owned the plantation since 1900, donated 251,334 square meters to the plantation workers. This area comprised 250 plots to be given to the workers, provided they built their houses in the plots allocated to them. The workers who succeeded in building a house would get title to the land. The plantation also set aside 40 plots to be sold for commercial purposes, one plot for the residence of a priest, one plot to build a church, two plots to build a school, and one plot for a market. The housing plots were numbered and named to constitute a residential nucleus. This residential area is now called Brasilia and it is also locally known as the Urarai Village or Park Maurice Bouysson.

The shift away from plantation housing preceded the mass movement that occurred thoughout the country from 1962 onwards, as a product of rural unrest and the promulgation of the Rural Workers Statute in 1963. This law gave workers the right to indemnization from plantation owners for loss of access to housing or to land for subsistence planting. Some proprietors gave the workers access to land and construction materials outside the plantation grounds; many houses in the plantation sites were destroyed. The plantation being studied still maintained 190 houses in the plantation site. During the research, the plantation had hired two engineering students to evaluate the total plantation housing condition.

This housing development preceded another very large migration out of plantation housing along public land surrounding main roads and the river. This squatter movement began in 1963. One worker declared she was the first person to move there, which was confirmed by many informants. She built her house across from a cluster of plantation houses known as the Black Cat Village. Her house marked the beginning of what became the squatter settlement around the main road connecting the city of Campos with Rio de Janeiro. Along the old road to Campos, a second squatter settlement began. Houses from this second squatter settlement were partially incorporated in this study, as they were occupied by very few workers in the plantation being analyzed.

Among the squatter settlements surrounding the plantation there is one which started on land around the Ururai River in an area characterized by seasonal river floods. This settlement is locally known as Ilha, or the Island, an allusion to the floods. Old maps indicate that this region was once within plantation boundaries, but when it was settled by squatters, plantation owners did not reclaim it. The settlement began at the same time as the other squatter settlements. They have a very active neighborhood organization and a mutual-aid system which operates particularly during the flood period. The neighborhood organization representative has spearheaded a movement to get the plantation to donate a nearby area that is less subject to flooding.

In 1968, the French corporation sold the plantation to a large Brazilian group that owns a large chain of businesses throughout the country, including several plantations in the northeastern and southern parts of the country. The new company managed the plantation during the sugar boom between 1965 and 1975 and during the production of alcohol as an automobile fuel additive, which began in 1978.

In 1977 the plantation donated 165,000 square meters to a housing development program which built 409 units for neighborhood workers. Housing changes at this time were favored by the creation of a housing development program (CEHAB) which built and commercialized working-class housing in land donated by the plantation. At this point, Petrobras, a Brazilian oil company, also acquired some of the plantation land and established a fuel distribution unit near the plantation. The housing built by CEHAB could also provide living quarters for Petrobras workers. The site where the low-income housing was built is known locally as Brilhante.

At this time, the sugar mill was modernized and a 125,000-square-meter area was set aside for this project; a distillery of 22,350 square meters also was constructed.

One house had weeds growing on the ceiling and in another, the walls were falling apart. During the harvest, when many residents did not pay their electric bills, electricity in the entire district was sometimes shut off. Towards the end of the research period electricity was being extended to the whole area.

Almost 36% of the persons surveyed were born after 1960. The experience of different generations regarding type of housing and the social control exerted by gender arrangements can be compared, and it can be found out whether gender hierarchy norms are losing strength as women emerge in the plantation workplace.

AGING, GENDER, AND LIFE COURSE

A central issue in the study of gender is finding out how society regulates biology, particularly the exercise of sexuality and fertility by women and men. Worldwide, societies regulate contact between women and men at the age in which they may procreate. This control is exerted more on women than on men. Women's contact with men is restricted by an attempt to keep them at home. This control has been radically altered with the advent of more effective contraceptive strategies.

In order to analyze changing patterns of gender arrangements in the households in a plantation, we have used a life-course perspective. Life histories were obtained from women living in a housing area surrounding an old but modernizing plantation. Aging, according to Riley *et al.* (1982) is influenced by societal changes. In addition, several authors, as reviewed by Featherman (1983), have stressed the importance of a life course perspective in an analysis of households' changes in order to link aging patterns to wider social processes (Vinovskis, 1988). The cohort groups selected for the interviews were drawn through the CASA data base managing system provided by the United Nations University, which sponsored the research. Gender is a key aspect of aging, a dimension related not only to biology, but, as a result of reproduction control, to the social expectations of everyday life activities. Reference points in women's life course, such as menstruation, sexual initiation, marriage or union history, pregnancy history, and menopause, can be examined. The importance of studying women's life cycle in comparative perspective has been pointed out by authors such as Brown (1981) and Caplan (1985). In Argentina, Jelin and Feijo (1983) emphasize women's biographies—the peculiarities for women as they move from childhood into adult roles and the patterning of domestic activities which this transition entails, as well as its effects on these women's income generating activities.

The life course approach allows changes in the women's life cycle as related to household and to the plantation environment to be observed. It also allows observation of changes in household organization and plantation environment. As the position of households in relation to plantation life changes, it is possible to observe if women gain more public access and if the social control over their sexuality and fertility declines.

Life histories were collected from 742 women who either worked or had coresidents working in the plantation.

Cohorts could not be preselected since the number of houses with persons working in the plantation was too small. Further, young people had migrated in certain areas of residence. A data base management system cannot be undertaken unless a large sample is obtained. I, therefore, chose to take all households in which there was at least one coresident working in the plantation.

Twenty-three life history matrixes focusing on distinct aspects of the interviewees lives were gathered. Besides a descriptive file the matrixes included housing, household, occupational, personal, marriage, pregnancy, and contraceptive use information for the interviewed, as well as information on the occupational history of the coresident. One matrix contained reference material for all household members with whom the interviewee had lived. Data on occupational history relating both to interviewed and coresident covered both primary and secondary activities for the harvest period.

A questionnaire with general descriptive data was also applied. It contained cross-sectional data which is used in this paper as general background information, and as one initial picture before moving into a life-course perspective.

BACKGROUND INFORMATION ON INTERVIEWEES

In order to understand the social regulation over women's sexuality and fertility, we have considered some significant factors in women's lives as these relate to their possibility of procreation. The first factor is age: 49.7% (369) were between 15 and 29 years old; 32.1% (238) were between 30 and 49; 18.2% (135) were 50 and over. Almost all the women in our sample had already begun menstruating (99.7); only two had not menstruated yet. Of the women in our sample, 72% indicated that they had had sexual relations with men; 28% indicated they had never had sexual relations. At least 28% had initiated sexual relations when they were between 11 and 17 years old; 16% after age 30. Postponing the onset of sexual relations was not a contraceptive strategy used by the women in our sample. Of all women who had had a companion, 70.3% were married, 17.6% had a consensual union, 9.1% were widowed, and 3.0% were separated. Only 8% of the married women interviewed indicated they had had a previous stable union before their current marriage. At least 67% had had children, and 46% had more than four children. Almost 19% were in menopause, indicating that the majority of the women interviewed could still have other children.

An analysis of the composition of the households yielded these results: In 29% of the houses where interviews were conducted, the father was a coresident and in 36% there was a coresidential bond with the mother; in 59% a spouse was present. The average size of the household was six persons. Twenty-five percent of the households had other relatives living there and 3.5% had nonrelatives residing in the house. Fifty-four percent of the households had only one income earner, 28% had two earners, 7.9% had from three to fifteen income earners, and 0.1% had no income earners at the time of the interview. The number of income earners decreased slightly after the harvest period.

Questions regarding coresidents revealed that there were 9,749 persons who had coresided with the 742 women interviewed. Their relationships were as follows: 12.4% were spouses; 16.3% were single daughters or sons; 6.0% were married daughters or sons; 0.5% were in-laws; 1.5% were grandchildren; 14% were parents; 41.3% were sisters- or brothers-in-law; 6.2% were other relatives, and 1.0 were nonrelatives; 51% of the reported household members were men and 49% were women.

Another important finding in our interview data was the extent to which there was a regulation of the patterns of personal relationship between women and men. Two different sets of questions were addressed to such issues: the first one referred to courtship patterns and the second one to the type of union.

Comparing the current generation to the previous one shows that 17% of the mothers of the women we interviewed had had more than one stable union, whereas 15% of their fathers had had more than one union; 2% indicated that their fathers had never married.

At least 22% of the women interviewed were going steady or were engaged to someone at the time of the interview; 94% indicated that their parents were aware. Only 31% of these said that they were subject to no control from their families. Thirty-two percent stated that they shared some sexual intimacy with their boyfriends and 29% had had sexual relations. Twenty-three percent of the interviewed who were going steady said that their parents controlled their dating a great deal, and that they would not even let them be alone with their boyfriend; at least 6% maintained relationships without the knowledge of their parents. Thus, some families still exercise control over their daughters, perhaps fearing early pregnancy. At least 33% of these young women's relationships ended by the end of the year. Eight percent had recently been sterilized, 15.6% used a natural contraceptive method sanctioned by the church, 0.8% practiced coitus interruptus, and 0.4% used condoms, indicating that male contraceptives were rare. Other unspecified methods were indicated by 18.2% of the interviewed.

Most household members were born in the State of Rio de Janeiro (98.4%). Forty-four percent of coresidents mentioned still live with the interviewee, and 30% of coresidents mentioned worked in sugarcane plantations.

This shows that in this area residents tend to stay in the vicinity. Even though throughout Brazil there have been large migrations to the urban areas, these plantation workers decided not to move. This stability is further enhanced by the fact that the interviews were conducted with women, who tend to stay longer than the men in the region. However, even though long-distance migration was not very common among those interviewed, there has been much mobility locally.

LONGITUDINAL DATA

The average number of houses in which each interviewee had lived varied. The overall period taken as reference is from 1911 to 1985. Older people, on the average, tend to have a much more varied residential history than younger cohorts, since they had had more time to move. However, the period after the mass expulsion from the land seems to have resulted in greater stability.

When cohorts are distinguished it is possible to observe that housework increased throughout the life course of the interviewees, but for older women it represented a main activity more than it did for the younger ones. To a large extent women devoted much of their time to nonremunerated activities, often supporting the work of coresidents in the rural and even urban industrial sector. Nonremunerated activities increased for the younger and the older women, whereas for the 30-49 year-old cohort, they increased at first but seemed to decline in recent decades. The rural labor family activities basically included sugarcane cutting, weeding, and transporting; the urban industrial labor included activities such as sewing jeans for local industries.

Throughout the life course, activities tended to increase, except for unskilled rural and industrial work which, on the average, decreased slightly for those 50 years old and older.

Data also showed that women have never performed skilled rural work, and that although the proportion of women in semiskilled and skilled urban industrial work increased slightly, they represented no substantive numeric growth.

Most of the work performed by the interviewees was nonremunerated work which tended to increase throughout the interviewee's life. Activities during harvest did not differ substantially from those done outside the harvesting period.

An examination of the occupational history of the coresidents shows that the average number of activities related to the sugarcane sector tended to increase with time, particularly in the industrial unskilled, semiskilled, and skilled work and in rural skilled work.

The average number of unskilled, sugar-related, rural work activities tended to decrease slightly, and this was also true for women. However, rural activities performed for the household also dropped dramatically, on the average. The only domestic activities which tended to increase deal with retired coresidents. This shows that women still remain largely tied to the household environment, even when they perform other kinds of activities. The household environment, however, may change. Men, on the other hand, tend to pursue activities outside of the household context, although retired men do perform household activities such as supervising children. The sexual division of labor and the separation of domestic and income-generating activities tended to increase, as men moved away from household activities. There is a trend toward a sharper separation of women's and men's activities in the household. Men's activities tended to remain the same during harvest and non-harvest times, but unemployment increased in the non-harvest period; on the average the 15-to-29-year-old group tended to perform different activities during harvest than during non-harvest times. Changes throughout the interviewees' lifetimes show that even when there are changes in the occupational composition of household members, these have not been sufficient to break women's domestic confinement, although there are also trends pointing in the direction of its break.

Throughout the interviewees' lifetimes, coresidents showed a greater tendency towards performing remunerated activities, although some overt unemployment, which increases with age, is also noted.

Also, although retired persons tended to stay at home as they aged, the very young may have had to do housekeeping while other family members worked for income. Retirement at earlier ages means that the worker obtained a social security license, generally due to a doctor-certified health condition. Some workers looked upon this as a strategy to gain some steady income. Any other work performed could add to the household budget. This type of social security is related to industrial workers; rural workers have a kind of social security now under revision, since it allows for only one retirement per household, generally leaving women out of the benefit.

Coresidents showed a growing tendency to work as unskilled rural workers and also as semiskilled and skilled industrial workers. They became skilled rural workers at the peak of their working lives. Unskilled urban industrial work tended to be performed when workers were more mature (a tendency which declines for the older cohort in the most recent period of time). The older age group tended to pursue self-employment and to perform nonremunerated family activities, more than the other cohorts; these tendencies increase with time.

Activities in the non-harvest period are not substantially different from those conducted during harvest. Unemployment affects the 15-to-29-year-old cohort group least; for the other cohorts, the tendency to become unemployed increases with age. It is also possible to observe that the activities of coresidents tended to become more stable with age. This tendency is increasing in recent times.

The older generation had a much more controlled dating pattern; to be young before the migration out of the plantation meant living under a much stricter social control than the current young generation has experienced. A freer dating pattern does not necessarily represent an increase in sexual intercourse, although this degree of intimacy in dating is more frequently reported in recent times than in the past.

An examination of courtship patterns and type of housing shows that plantation houses exerted the most control over courtship patterns and squatter houses the least. Social control, however, was neither all-encompassing nor did it disappear completely. Respondents stated that when parents were too strict they found ways to meet their friends and escape control. Even when relations were freer, in certain quarters some supervision was maintained to avoid early pregnancies which would result in the grandmother being responsible for raising the child. It also has been shown that in poor neighborhoods where there was no supervision over courtship patterns there was a tendency for early unwanted pregnancies (Hogan, 1985, pp. 825–855). This underscores the need for early sexual education.

The data on marriage history shows that women in the 30-to-49-year-old cohort, on the average, reported more engagements than any other. In general, engagement rituals seem to be decreasing. Marriage is reported throughout the life course, and marriage of women under 14 years old is common. The figures also show that consensual unions are on the rise and, except in the 15-to-29-year-old cohort, the average number tended to decrease.

Contraceptives were used widely in the plantation being studied. The preferred method for all cohorts was the pill. Sterilization was reported by all age groups, but, on the average, it has been used more by the 30-to-49-year-old cohort; natural methods endorsed by the church have been favored by older age groups. At the time of the interview, contraceptives which depend more on the men had been on the decline.

The interviewees showed a tendency for early pregnancies, which increased at first and then seemed to decrease. The older cohort had a pregnancy history of six children on the average. With the trend for early marriage or consensual union, unless effective birth control methods continue to be used, fertility will remain high. On the average, the older cohort reported more children born dead, a trend that has tended to decline.

Finally, the average number of spontaneous abortions has been decreasing; elective abortions were little reported, but showed a slight tendency to increase.

If contraceptives are not used, the trend towards more freely chosen sexual relations will lead to large families, and may, in fact, reinforce trends towards household chores. The trend towards consensual unions may result in women becoming the heads of households. However, far from serving to break them away from a gender-dominated world, this may just throw women into a situation of poverty.

CONCLUSION

This paper shows the different housing experiences that different cohorts of women connected to a plantation have had. Older cohorts, who were young before the mass movements from the plantation quarters began, had much more stable housing patterns than the ones who are young now but who maintain ties to the plantation. The older women had less of an urban industrial work history. The cohort which was young before the migration out of the plantation also show the same tendency; this tendency is reversed only for the young cohort which lived outside the plantation after the migration. Housework, however, tends to increase for the older generation. Older women are more likely to have unemployed, nonremunerated family members, and retired persons as coresidents, as well as unskilled and skilled urban industrial workers, who may substantially contribute to the household's maintenance. Those who were young before the large-scale migration out of the plantation experienced much more rigid control over their courtship patterns; those who dated when they were older experienced less control, and the younger generation had less control over their courtship patterns. Those who were young before the migration, tended to retain rituals such as engagement and marriage.

The younger cohort tended to use more contraceptive methods after the large movements away from the plantation housing. Those who were young before the migration had a much higher early pregnancy history than those who were young after the migration. As expected, older age groups had a much higher pregnancy history resulting in live births. Those who were young before the migration out of the plantation also had a higher tendency to have had children born dead or to have had spontaneous abortions, showing that the patterns of health attendance improved.

The paper shows a high differentiation of plantation life according to age and to the modernization patterns in plantation life.

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ROLE CHANGES IN WOMEN AT MIDLIFE IN ARGENTINA

Zulma Recchini de Lattes[1]

By the beginning of midlife (defined here as between 50 and 59 years of age) most women have married and, moreover, have practically completed their families. Towards the end of this period, most of the children will have left their parents' home and, though the majority of women will continue to live with their spouses, many will be widowed. Between ages 40 and 49, an increasing proportion of women participate in economic activities, and most of them retire between 50 and 59. The lives of older women, which have been shaped by their experiences as young women, will in turn influence their attitudes and behaviors in old age.

This paper presents the changes in economic participation of several generations (or birth cohorts) of older Argentine women, based on information from the population censuses of 1960, 1970, and 1980. The main purpose is to show that in recent decades, the economic participation of older women in Argentina has grown with respect to the same group's participation at younger ages (30 to 39 years), a behavior different from that of earlier generations of women when they went through similar stages of their life cycles. This change in behavior will doubtless affect the future life of these women and will influence the conduct of the younger women of today; this allows us to speculate about the roles of midlife and older women in future decades.

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CHANGES IN PARTICIPATION THROUGHOUT THE LIFE CYCLE

During the 1960s and 1970s, female participation in economic activities in Latin America was on the increase (Katzman, 1984). The most notable increase in Argentina was produced among women between 35 and 54, for whom the rates rose more than 50% between 1960 and 1980, while they rose only 5% for young people between 20 and 24 (Figure 1, thick lines).

If instead of comparing rates for women of the same age at different moments in time, we follow the evolution of different birth cohorts of women[2] every five years as they age (thin lines in Figure 1), it is observed that: a) as usual, the participation of all female cohorts observed in Argentina declines after its peak at 20–24 years until 30–34, but the decrease is less marked in recently born cohorts; b) the cohorts with higher rates of

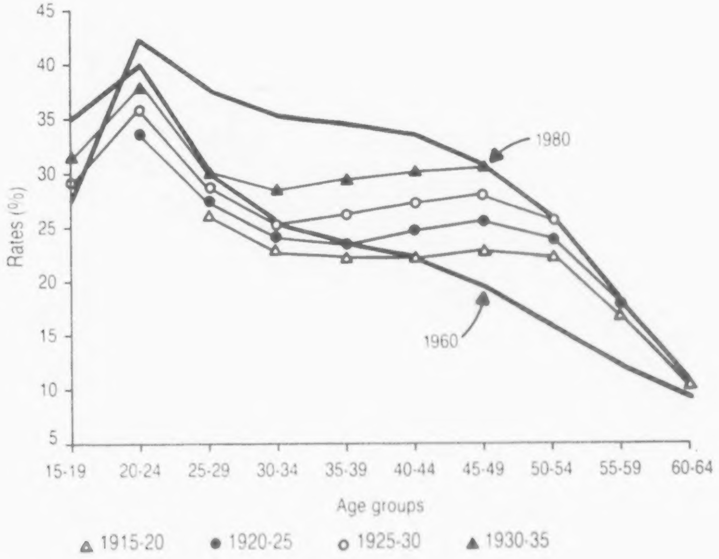

Figure 1. Female participation rates.

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[2] The cohorts have been drawn beginning at age 15–19 or for the age for which information is available. The cohort curves are actually incomplete due to a lack of information.

participation in their youth continue to have higher rates than other cohorts throughout their entire active life cycle; c) the curves for participation of the cohorts born between 1920 and 1935 tend to have a second peak at 45-49 years. This second peak in participation was observed for the first time in the 1960s among women entering or already in midlife (Recchini de Lattes and Wainerman, 1978), and continued in the 1970s for more recent female cohorts. In other words, during recent decades a new trend has been observed in Argentina: many women have entered the labor force between 30 and 49 years of age.

CHANGES IN MARITAL STATE AND ECONOMIC PARTICIPATION

In general, women's participation in the labor force varies greatly in accordance to their marital status, and Argentina is no exception. Women with a companion (married or living together), especially those who are legally married, have the lowest rates of participation at all ages, while divorced and single women have the highest, and widows have intermediate rates. The differences between women with and without a companion persist even at ages when the demands created by the presence of small children have disappeared, and the weight of family obligations among married, widowed, single, and divorced women is, if not equal, at least similar.

The majority of women marry young, and by the time they reach midlife, most of them are married or living with a companion. In Table 1 we can follow three 10-year cohorts of women between 30-39 and 50-59 years (or incomplete parts of those ages) and observe the changes produced in the composition of the groups by marital status. It can be seen that, in fact, about 80% of women 30-39 years of age live as a couple (married or living together) and that this percentage decreases noticeably as they age, even though, as indicated by the decrease in the proportion of single women, a significant percentage get married or begin to live with a companion at these ages. Only about 70% of those between 50 and 59 years of age are still married or living together in consensual unions. At the same time, the proportions of widowed and divorced women increase markedly as women go from 30-39 to 40-49 and 50-59 years of age.[3]

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[3] For example, the proportion of divorced women from the 1920-1930 cohort tripled when these women went from 30-39 to 40-49 years of age during the 1960s (Table 1); this was due to a significant change in the divorce norms during that decade. Such a notable increase in the number and proportion of widows in the same decade was mainly due to the considerable increase in the mortality differential by sex that occurred in those years, which favored women much more than in past periods.

Table 1. Distribution by marital status of various older female cohorts in 1960, 1970, and 1980.

Year	Age	Married	Living together	Widowed	Divorced	Single	Total
			1910-1920 cohort				
1960	40-49	74.19	5.27	5.60	1.27	13.67	100.00
1970	50-59	64.07	4.98	15.60	3.12	12.23	100.00
			1920-1930 cohort				
1960	30-39	75.23	5.81	1.49	0.94	16.53	100.00
1970	40-49	73.51	6.37	5.48	3.32	11.32	100.00
1980	50-59	65.42	5.70	14.36	3.95	10.57	100.00
			1930-1940 cohort				
1970	30-39	73.02	8.09	1.72	2.69	14.49	100.00
1980	40-49	72.10	8.22	5.13	4.40	10.15	100.00

Source: Calculations based on census data.

Not only was there a change in the marital status configuration of women entering or already at midlife, but there was also a change in their rates of participation in the labor force. Thus, as can be seen in Table 2 by following the participation rates by marital status of the same three cohorts of women as they age, the married women, and, even more, those living with a companion, increased their participation rates between 30-39 and 40-49 years of age in the 1920-1930 and 1930-1940 co-

Table 2. Participation rates by marital status of various older female cohorts in 1960, 1970, and 1980.

Year	Age	Married	Living together	Widowed	Divorced	Single	Total
			1910-1920 cohort				
1960	40-49	12.3	14.3	35.9	56.9	57.3	20.5
1970	50-59	11.7	19.7	24.9	44.3	43.8	19.1
			1920-1930 cohort				
1960	30-39	14.0	12.5	49.0	67.3	66.0	23.5
1970	40-49	17.3	21.5	55.3	66.6	65.0	26.7
1980	50-59	15.2	23.4	24.9	50.3	46.3	21.7
			1930-1940 cohort				
1970	30-39	20.9	21.6	59.5	76.2	71.2	30.4
1980	40-49	23.8	30.1	46.0	71.0	65.3	31.8

Source: Calculations based on census data.

horts, as was also the case for widows in the 1920-1930 cohort. In contrast, single and divorced women of the same two cohorts and widows of the most recent cohort reduced their participation in economic activities during these stages of their lives. On the other hand, almost all groups of women defined by marital status of the cohorts of 1910-1920 and 1920-1930 decreased their participation in economic activities as they went from 40-49 to 50-59 years of age, including married women. The only exception were women living in consensual unions who also increased their participation rates during this stage of their lives.

How can the changes in marital status configuration and participation be combined in order to explain the second peak in participation observed for the group of older women in cohorts that reached these ages in recent years? The reasons for women who are going from 30-39 to 40-49 are different from those for the women who are going from 40-49 to 50-59 years of age.

For the former, as shown in Table 3, the women of the 1920-1930 and 1930-1940 cohorts of any marital status except single women made a positive contribution to the increase in participation rates that produced the peak at older ages. But the reasons are different for those who live as a couple, on the one hand, and those who are widowed or divorced, on the other. Women who were married or living with a companion contributed positively because the *increase* in their *participation rates* (Table 2) more than offset the *decrease* in the total *number* of women of these marital

Table 3. Distribution of the increase in older active women of various cohorts, 1960-1970 and 1970-1980.

Period	Age at end	Married	Living together	Widowed	Divorced	Single	Total
			1910-1920 cohort				
1960-1970	50-59	−84.3	6.9	68.5	23.9	−115.1	−100.0 (−29070)
			1920--1930 cohort				
1960-1970	40-49	104.6	35.3	93.9	88.0	−221.8	100.0 (25871)
1970-1980	50-59	−61.1	−1.8	19.8	−5.8	−51.2	−100.0 (−75825)
			1930-1940 cohort				
1970-1980	40-49	261.8	118.8	228.4	178.9	−687.9	100.0 (8729)

Source: Calculations based on census data.

statuses (Table 1). Widowed and divorced women contributed positively despite the *decreases* observed in their *participation rates* because their *number increased* tremendously. In other words, both the increase in the participation rates among women married or living together, and the changes in the marital status configuration which resulted in an increased proportion of widowed and divorced women, contributed positively to the second peak observed in the participation rates as the female cohorts went from 30-39 to 40-49 years of age.

The group of women who went from 40-49 to 50-59 years of age decreased their participation rates, whether they were born in 1910-1920 or 1920-1930 (last column of Table 2). But it is interesting to observe the dynamic of this change. Table 3 shows that for the 1910-1920 cohort both widows and divorced women, but especially the former, increased the number of active women despite, once again, the decrease in the specific participation rates, due to the enormous increase in the number of women of these marital statuses that was produced during the decade. This increase was also slightly contributed to by the women living with a companion, not because there was any increase in their number which, as previously stated, declined, but because the increase in their participation rates managed to offset it. The increase was not enough, however, to compensate for the reduction in the number of active single and married women, for which reason the total number of active women in the cohort decreased (and their participation rate went down). On the contrary, among those who went through this stage of the life cycle in the 1970s (1920-1930 cohort), only the widows contributed, and very slightly, to offset the decrease in the active women observed for women of the other marital statuses. Women living in consensual unions, who, again, were the only ones to increase their participation rates during this stage of the life cycle between 1970 and 1980, did not manage to offset the decline produced in their number.

CONCLUSIONS

In recent decades, the participation of Argentine women in the labor force has been increasing as they become older. This has occurred mainly for two reasons: on the one hand, the growing incorporation of married women into the labor force and the even faster growing incorporation of women living with a companion, and, on the other, the change in marital status configuration in which many women who were married or living with a companion became widowed or separated and, on doing so, adopted the participation norms characteristic of women not living with a companion, that is, many of them joined the labor force.

It is risky to conclude that this trend has helped to improve the lives of these women without analyzing the occupations in which they have worked. Rather, it is thought that a significant proportion of those who entered the labor force did so because it was their only alternative rather than because it was an option they had chosen. But it can be assumed that these women will be better covered by retirement laws when they are older than those women who did not participate in the labor force.

If this increase in participation at older ages is imitated by the young women of today when they reach those stages of their lives, though it is difficult to predict for the group as a whole, a clearer picture emerges if we speculate separately for women living in couples and for those who are widowed or divorced.[4] On the one hand, if women who are married or living as a couple continue to increase their participation rates as they have in past decades, since they will undoubtedly constitute the majority of older women, the second peak in participation rates of the female cohorts will probably appear again in 1990 and the following years. This becomes likely because of both the economic crisis of recent years and the examples of divorce, and because increases in participation of women of previous generations will probably push married women and those living with a companion into the labor force.

On the other hand, different factors influence the variation in the number of divorced and widowed women. The number of the latter depends on both the typical age differential in marriage, by which women usually marry men older than they are, and the equally typical mortality differential by sex, which favors women. If the mortality differential by sex in Argentina decreases as has been occurring in recent years in the developed countries, the proportion of older widows will decrease with the increasing average life of men. If the typical age differential at marriage changes so that women marry younger men—a change perhaps not difficult to influence—this change would also contribute to future generations living longer in couples, that is, this would reduce the proportion of widows in upcoming generations of older women. Such would be the configuration effect of the change.

It may also be thought that older widowed and divorced women of coming generations will not decrease their participation rates at older ages as notably as they did in recent decades, especially if they were already in the labor force when they were married or began living together. If their levels of participation were to increase, or at least remain constant, this effect would be added to the effect of the change in marital status which in any case will still be produced during this stage of the life cycle. That is, they too, as well as women married or living with a companion, would contribute to an increase in economic participation at older ages similar to or greater than that observed in recent decades.

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[4] It is assumed that both the number and participation rates of single women, who probably joined the labor force when young, will decrease as they reach older ages.

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THE INVISIBLE WORKER: HEALTH CONDITIONS OF THE DOMESTIC WORKER IN COLOMBIA

Magdalena León[1]

This work primarily aims to point out the health conditions of the domestic worker, with special emphasis on the older worker. Before tackling the subject, we want to distinguish between domestic work assigned to women and paid domestic work or domestic service, and show the extent of the latter.

It is important to differentiate domestic work that is culturally assigned to the woman in her role as homemaker, mother, or wife from paid domestic work performed by a woman who seeks income for her work and who does it for a family other than her own.

The domestic work done by a homemaker, mother, or wife is clearly undervalued socially, which translates into the subordinate status of women in society. Paid domestic work acquires the social undervaluation of domestic work. Furthermore, because it is done by women from the lower class sectors of society and involves a relationship marked by servitude, its social devaluation is increased. Thus, the paid domestic worker turns into an invisible worker because her labor is not socially recognized. Added to this is the spatial isolation in which she carries out her work, which reinforces the anonymity of both the individual and the group of domestic workers in society.

There are two kinds of paid domestic worker in Colombia: the live-in worker who lives in her employer's home, and the daily worker who lives outside the home, comes in only during the workday, and may work for several employers simultaneously.

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DIMENSION OF THE PROBLEM

How many domestic workers are there in the country? How are they related to the female work force? Are they increasing or decreasing? Is paid domestic work on its way out as a function of the development and modernization of society? What is the age structure of the group of domestic workers? What is the population of older women among domestic workers?

These and other questions will enable us to point out the extent of the problem with regard to the volume of paid domestic work and its proportion in female employment. The answers are limited by the kind of information available.

In the first place it should be pointed out that the large numbers of paid domestic workers in the female work force is a clear-cut phenomenon. In 1985 one of every five women who worked in the major cities was in domestic service (Puyana, 1987).

This high proportion has increased or decreased according to economic circumstances. According to conventional statistics, domestic service has decreased drastically in the last three decades. In the 1951 census, 43% of the women in the economically active population were in domestic service as live-in workers. For 1973 this proportion declined to 24% (García Castro *et al.*, 1972). According to data from home surveys, from 1974 to 1978 domestic service decreased from 26% to 16% (Campillo and López de Rodríguez, unpubl.).

Some enthusiastic analysts have used these figures, disregarding the fact that they are underestimates, as evidence of "modernization" of the occupational structure. This analysis has been made without examining the difficulties involved in conventional statistical counts due to methodological and conceptual problems in the measurement process. In counting domestic service workers, we could say that "Not all that are, are there," so that the data contribute to the *social invisibility* of the domestic worker. Not included are the younger workers or the daily workers, and the occupation is confused with unpaid housework and with workers who are independent or work for themselves.

Rather than tending to disappear or drastically decline, the group has been experiencing internal change: that is, the live-in domestic worker is giving way to the daily worker. At the end of the 1970s, a survey (Nohora and Rey de Marulanda, 1984) that included both types of domestic service showed that for the country's five major cities, 37% of the female labor force was employed in domestic service.

The severe economic crisis of the 1980s—which had a negative effect on female employment, and particularly that of lower-class women—seems at the same time to have led this sector of women to offer to work in paid domestic service, especially in daily work, as a means of survival. Furthermore, the decrease in real salary of the middle classes has led women in these strata to join the labor force and, therefore, to seek a partial "replacement" for their domestic obligations. We submit the hypothesis that it is this double occurrence in the labor market that has maintained the high numbers of domestic workers in female employment.

With regard to the age composition of the group of domestic workers, 1984 data from Bogotá, Medellín, Barranquilla, Cali, and Cúcuta reveal a young population with average ages ranging between 17 and 22 years for the 15-34 age group. The data also show average ages between 47 and 49 years for the 45-60 age group. According to the Home Survey, stage 44, this indicates that most of the workers are younger than 50 years of age.

Data for Bogotá in 1988 show that 56% of domestic workers are younger than 34 (concentrated in the 20 to 24 year age group), 23% are older than 45, and 4% are 60 years or older. These are cases of live-in and daily domestic employees who have requested jobs through the ACEP program.[2] If this information is compared with data on daily workers from the Employment Offices of the District of Bogotá,[3] we see a decrease in those younger than 34, who represent 46% of the group, and an increase in those in the 35 to 44 year age group (29%) and in those who are 45 and up (more than 25%). These data reveal a concentration of older women in the group of daily workers. If we take into account the changes taking place in the group's internal composition, that is, the live-in worker giving way to the daily worker, we could hypothesize an increase in the group of older domestic workers.

RIGHTS AND HEALTH CONDITIONS OF DOMESTIC WORKERS

As a general rule, the domestic worker is completely unprotected with regard to health problems related to maternity, disability, and old age, in spite of the limited rights conferred by law.

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[2] The data are for a sample of 2,492 cases.

[3] Employment Program of the Administrative Department of Social Welfare of the District of Bogotá, DABS. The data are for a sample of 923 workers.

The labor provisions that do exist with regard to illness and work-related accidents of the domestic worker are limited in Colombia. There is a right to medical care and the required drugs in case of illness, and a right to first aid and emergency treatment and medicines in case of accidents. However if a domestic worker has serious sequelae from an accident, or more than one month of disability due to illness, she is not protected by law because the employer has no further legal obligation; this situation makes the provision discriminatory.

Even more serious than the legal discrimination is that the limited provisions on accidents and illness that do exist are not implemented—much less the provisions on maternity, which are the same as those for other working women: the right to 56 days of paid rest and the right not to be laid off while pregnant.

Furthermore, the occupational illnesses of the paid domestic worker are not recognized in existing provisions. Domestic accidents, which have been extensively analyzed for housewives, are particularly likely to occur to the paid domestic worker due to her high degree of vulnerability in this occupation, but this is not recognized as occupational illness either legally or socially.[4]

The lack of basic information makes it impossible to give a quantitative summary of the health conditions of the domestic worker or to point out the differences by age group in order to better understand the situation of the older domestic worker.[5] For this reason we present a more qualitative overview and point out some of the problems.

The young worker recently arrived to the city feels the lack of health protection less, given her temporarily low level of risk. However, once her reproductive cycle has begun and she must confront the risks of gestation and birth, or when, as the years go by, common illnesses or more complicated diseases begin to appear, a worker's complaints and accusations will mount, due to the innumerable daily problems brought on by her lack of protection by law and society.

Among these problems we can mention absences from work (resulting in no income) for daily workers; reluctance, discouragement, and fatigue in carrying out tasks due to the presence of chronic illnesses; the lack of resources to go to the doctor and buy drugs; the illness of children; anxiety and loneliness when ill; the loss of employment, and many other consequences that affect interpersonal relationships at work, in the family, and in one's emotional life. This picture of impaired health conditions and their consequences on employment and life bespeak the subtle presence of a psychological violence generated by the worker's complex subordinate social status which is expressed in daily suffering, depression, nervousness, and stress. These factors become more acute when the worker reaches the end of her reproductive life, or menopause, and must face the arrival of midlife and old age. All the foregoing do not even mention the degree of physical violence (blows, mistreatment, rape, etc.) that still occur in work relations and family life.

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[4] Domestic accidents among housewives, understood as the level of risk of domestic tasks and their relation to the illnesses originating from them, has been studied by Argelia Londoño. See "El Sindrome del Ama de Casa," in *Avances y Perspectivas en los Estudios Sociales de la Familia en Colombia*. Bogotá, ICTES, 1983.

[5] In order to correct this lack of information, a survey was designed that included basic health conditions. This survey was carried out in June and July 1988 among daily workers of the Employment Offices of the Administrative Department of Social Welfare of the Mayor's Office of Bogotá. Processing and analysis of the survey are pending. See Annex 1 of this article.

When the employee must work a double workday, that is, when the daily worker must do the domestic work for her own family after completing the day's labor in her employer's home and after long, uncomfortable hours of commuting, the impairment to her health leads to high levels of risk to her physical and emotional stability. Furthermore, 35-year-olds constitute the largest group among daily workers, while health conditions are most precarious for the age group beginning at 40 years.

It can be said that not only does the domestic worker suffer precarious health conditions that affect her daily life, but that the lack of legal protection and noncompliance by employers with existing provisions "deny her the right to be ill. Often, when illness occurs, her vacation time is moved forward so that she will have recovered from the illness on her return" (Garcia Castro *et al.*, 1972). It should be mentioned that this occurs in the best of cases, since often to become ill or pregnant is synonymous with the loss of employment. Of 333 cases of workers no longer in the labor force, 30% mentioned pregnancy, illness, or old age as a cause; of 633 workers who terminated their work contracts, 45% indicated pregnancy, illness, or old age as the immediate cause of their decision.

For very elderly workers, illness represents unrelenting unemployment. One older employee expressed it this way: "I am old and ill and cannot work and I have no protection." Furthermore, employment offices have established age limits. In this way, women who have devoted their entire lives to domestic work (usually beginning as minors) find themselves expelled from the labor force when their health is clearly impaired, which usually occurs at 40 or more years of age. According to the ACEP sample, 28.5% worked for the first time in domestic service at 14 years of age or less, and 58% did so before reaching 20 years of age. These data show the early age of entry into the job market and are important in understanding how this kind of work consumes not only the person's life on the job, but longer time periods which may be associated with the emergence of premature aging. The figures show that 54% of domestic workers have 10 or more years of service, and of this group 28% are older than 20 years of age. If Social Security services had covered this population, today the former group (54%) could choose half pension on retiring at 55 years of age, and the latter group (28%) could have a full pension.

As will be seen further on, social security has not been effective; many women who began their employed life at an early age find themselves fatigued and facing loss of their job at 35, 40, or 45 years of age. Furthermore, not only are older domestic workers expelled from the labor force without receiving old-age support, but it is not uncommon to find a history of domestic employment among beggar and street women with mental problems.

The experience of health problems as they affect the personal and daily lives of domestic workers has been collected in testimonial form in the courses and workshops of a training program. This program forms part of a research-action project[6] which, as part of the information feedback process, has grouped the testimonies in a single voice and presents them as teaching material in a brochure (Eljach *et al.*, 1988) that condemns the situation and serves to recycle the same teaching program.

This collective testimonial dramatically shows the obvious lack of protection for illness, pregnancy, and birth. Sections of the brochure are quoted in the following paragraphs.

Illness. For the live-in worker: "Most employers take no interest in the state of our health. When we are ill, as long as we are able to walk, we must work even with pain or fever. When we can do so no longer, some employers will pay for a doctor's visit, but if we need analyses or x-rays, it comes out of our salary. If the illness makes us unable to work, they send us home to recover, but without salary. On our return, we almost always find that we have been replaced. In case of hospitalization, we are fired or they give us a 'loan' to be taken out of our salary."

For the daily worker: "The situation is worse. We almost never receive medical care. When we are ill and cannot go to work, we receive no wages for the day. Neither we nor our employers are aware of our right to receive medical care. Thus, if we lose several days due to illness, we also lose our jobs because they look for a replacement."

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[6] The project, "Activities to Transform the Social and Labor Conditions of Domestic Service in Colombia," seeks to change the type of conditions that lead to situations of exploitation and subordination for the domestic worker. Among the activities carried out are the provision of legal assistance to the worker and training about women as workers through courses and workshops. For an overview of the program, consult Magdalena León, "Domestic Labor and Domestic Service," in *Empowerment and the Law*, Margaret Schuller (ed.), OEF International, 1986.

Pregnancy and birth. For the live-in and daily worker, the situation is the same: "We all know that our employers don't like us to get pregnant. From the beginning they warn us about this and ask us if we are expecting a child in order not to give us a job. Therefore we ourselves feel that it is a problem to have a child, and many of us quit and find ourselves in need. In most cases, if we don't quit, the employer fires us when she finds out. If we are lucky enough not to get fired, when it is time for the birth they take us to a hospital and if we have no savings to pay the bill, they pay out of our salaries or they give us a loan.

"We take our babies and go to live with relatives, and we return when we feel recovered. We are not paid for this time. Many women are already back on the job at their employer's house only a few days after the birth. This seriously affects our own health and that of our babies."

On-the-job accidents. "When we suffer an accident on the job, the same thing happens as with illness. They take care of the emergency when it is minor. When there are serious consequences, we are unprotected. And if there is disability, we run the risk of losing our jobs."

Old age. "After a lifetime of working in a family's home, when we become old, no one gives us work. Many of us end up having to beg in order to survive or we become a burden to our families. Thus we spend our lives helping our employers to get ahead and in the end we are left alone, with no protection: neither housing, nor health, nor pension, because the right to be affiliated with Social Security, though it has existed since 1977, is not recognized by employers, who didn't even know they had to cover us, and we didn't either."

This collective testimonial shows the pathetic reality and discrimination with which this large group of women lives.

When the domestic worker finds health care, this is seen as an "act of employer good will," as a support from the network of family or friends, or as a personal expense that is extremely costly in relation to income. According to data from the project on "Activities to Transform the Social and Labor Conditions of Domestic Service in Colombia" of ACEP, of 1,402 cases of workers in Bogotá who required medical consultation, 61% personally paid the costs, and 72% had to pay the cost of drugs out of their own pockets. In addition, the domestic worker, as part of the lower classes, uses government services that are insufficient and inadequate for the general community. In this way, medical care, considered as a favor from the employer, becomes a "salary in kind" and varies in coverage and quality according to the employer. Thus a right that is assured, if only partially, in the law, turns into one more element to strengthen the workers' ties of dependence on their employers, and expresses the limitations of social citizenship.

This disregard for the right to health or, in other words, the right of thousands of domestic workers to dignity in the silence, anonymity, isolation, and invisibility of their daily life, was what triggered participation in the struggle that brought this group's lack of protection out into the open.

SOCIAL SECURITY CAMPAIGN

In 1977 domestic workers were included in the national Social Security system by means of a provision that did not specifically mention them, but covered them in fact. This right was not generally known, and the consequence 11 years later was total noncompliance with the provision, the "Decade on Women" notwithstanding. Thus, not only were labor provisions on health not made effective, but Social Security was not applied either, resulting in a complete lack of protection.

Given this noncompliance and in order to make the provision known within the State, in public opinion, and among domestic workers and their leaders, and to seek its implementation, the Campaign for Social Security was carried out between 1985 and 1988.[7] This permitted the group to mobilize public activities, first in Bogotá and later in the country's other main cities (Medellín, Cali, Barranquilla, and Bucaramanga), which achieved national coverage. Different types of events were held, such as demonstrations, marches, and different types of publicity, as well as an active effort to exert pressure through mass media. As the campaign progressed, the group came to speak for the State and society.

In 1985 more than one thousand women workers in Bogotá broke with their assigned roles of social invisibility in a public act held in the Plaza de Bolívar, the political center of the country: they signed a letter addressed to the then-President of the Republic condemning the lack of health protection and requesting a solution to make existing Social Security provisions effective. In 1986, workers in Barranquilla held a "March of the Aprons" for the Minister of Labor who was from that city. This act was the first public march of women in the city and, since the women were domestic workers, it had tremendous impact. In 1987 the group continued its pressure on the new President of the Republic and, following a march in Bogotá with nationwide participation, a new letter to the President was signed.

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[7] An analysis of the subject can be found in Magdalena León, El Servicio Doméstico también es Colombia, Bogotá, May 1988 (mimeograph).

The break with social invisibility and anonymity came about thanks to the consciousness-raising and publicity achieved through training courses and workshops held by the domestic workers, which have made it possible to form stable groups of workers who condemn the situation and fight for their rights. The courses and workshops serve to make the labor provisions known, to point out the discrimination they contain, and to teach women about their identity as women and as citizens.

As a direct result of the pressures exerted by the group since 1985, there was a governmental initiative in August 1987 to present a draft bill to the Congress of the Republic to make effective the Social Security provision that had existed since 1977 for the domestic worker. The group exerted continuous pressure, lobbying the executive and legislative branches and appealing to public opinion during the discussion and revision of the initiative. This new stage enabled the group to gain more social visibility, to the point that the coalition of forces in favor of the initiative made possible its final success: a new provision was approved in the Congress of the Republic, received executive confirmation in January 1988, and was regulated by the Institute of Social Security on 29 April 1988.

The new provision permits the Social Security to provide full coverage of domestic workers for illness, occupational accidents, and maternity, even though the cost of membership is less than for other workers. The provision also allows the State to subsidize the payments not covered by employers and workers, so that old-age pension will never be less than the legal minimum wage.

In this way, the Campaign for Social Security resulted in a new provision which, if implemented, will alleviate the health conditions of the domestic worker and permit her in the long run to enjoy an old-age pension.

We should question whether the climate created in public opinion—that is, the visibility of the social conditions of the female worker—will be a dynamic factor in changing attitudes and behaviors that will avoid failure in implementing the provision, and, most important, if the group's still weak organizational capabilities can be dynamic factors in the short and long run to transform their legal achievement into reality.

FINAL POINTS

The most important points to highlight from this brief analysis are:

- When the health problems of domestic workers are analyzed, we are speaking of a large sector of lower class women and of a large group in the urban female labor force.
- The health philosophy promoted by the World Health Organization, according to which health is defined as "...physical, mental, and social well-being," and which implies an emphasis on health prevention programs and not merely curative ones, is only an illusion for domestic workers. As a social sector, they do not even have access to curative services, and the preventive ones are light years away from their daily lives.
- Given the early age at which the domestic worker enters the labor force and the precarious state of her health, she ages prematurely. Old age begins early due to the complex situation of physical and emotional deprivations that she must bear in her family and work life.
- The lack of protection becomes even more acute in old age. The deterioration of the woman's health means the loss of her job. After a lifetime of work, she ends up begging for charity in order to survive, or she becomes a burden to her family. Social security has not yet been made effective, and the old age pension will be for future generations only if the new provision that was recently approved due to the domestic workers' pressure in the Campaign for Social Security is actually implemented.

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ANNEX

Survey used in the Program of Activities to Transform the Social and Labor Conditions of Domestic Service in Colombia—ACEP.

Employment Office: ____________

Name of Worker: ____________

Date: ____________

1. Days worked last week

House	1	2	3	4	5	6
Days						

Total days: ________

5. Years working in domestic service:
1 year or less ( )
2-3 years ( )
4-5 years ( )
6-9 years ( )
10-14 years ( )
15-19 years ( )
20-29 years ( )
30 or more years ( )

7. Place of birth:
Rural area ( )
Small town ( )
Small city ( )
Large city ( )

9. Number of children born alive:
( ) 0 (__)

11. When your last child was born, did you work in domestic service?
No children ( )
Yes, in domestic service ( )
Not in domestic service ( )

12. If you were working during your last pregnancy, what happened?
Not working ( )
Fired before the birth ( )
Fired after the birth ( )
Left voluntarily ( )
Continued working ( )

14. During your last pregnancy, were you under medical supervision before and after the birth?

	Before	After
No children	( )	( )
No supervision	( )	( )
1 visit	( )	( )
2 visits	( )	( )
3 or more visits	( )	( )

2. If you worked less than six days, did you wish to work more?
No ( )
Yes. How many? ________ ( )

3. Age: ________________ years

4. Age on entering domestic service:
______ years

6. Education:
None ( )
Incomplete primary ( )
Complete primary ( )
Incomplete secondary ( )
Complete secondary ( )
Other: ____________ ( )

8. With whom do you live?
Employer ( )
Companion and children ( )
Children ( )
Relatives ( )
Friends ( )
Alone ( )
Other: ____________ ( )

10. Marital status:
Unmarried ( )
Single mother ( )
Married ( )
Free union ( )
Widow ( )
Separated ( )

13. Where did you have your last child?
Hospital or health center ( )
Private clinic ( )
ISS, as member ( )
ISS, through companion's membership ( )
Home ( )

15. Who paid the expenses for your last birth?
No children ( )
Free ( )
Employer ( )
Yourself ( )
Employer and yourself ( )
Father of child ( )
Other. Who? ________ ( )

16. During your last pregnancy, did you have paid maternity leave? (56 days of leave)

No children	( )
No leave	( )
A few days. How many?	( )
Full leave	( )

17. Your pregnancies and births have been:

No pregnancy or birth	( )
Normal	( )
Complicated	( )

18. Have you had any miscarriages?

No	( )
Yes. How many? ________	

19. Have you been ill in the last 12 months?

Have not been ill	( )
Minor illness, but not bedridden. What illnesses? ________________	( )
Moderate illness, bedridden. What illnesses? ________________	( )
Serious illness. What illnesses? ________________	( )

20. Have you sought any health consultation in the last 12 months?

a. Where		*b. Payment by*	Consultation	Drugs
None	( )	None	( )	( )
Hospital or health center	( )	Free	( )	( )
Private clinic	( )	Employer	( )	( )
Private physician's office	( )	Yourself	( )	( )
ISS—"Caja de previsión"	( )	Employer and yourself	( )	( )
"Caja de compensación"	( )	Husband or children	( )	( )
Drugstore	( )	Loan	( )	( )
Other: ____________	( )	Other: ________________		

21. Have you been hospitalized in the last 12 months, and why?

No	( )
Pregnancy	( )
Work-related accident	( )
Other. What? ________	( )

22. In the last year, have you had to stop working due to illness?

Never	( )
Sometimes	( )
Often	( )
Very often	( )

23. When you stopped working because of illness, were you paid?

Never	( )
Rarely	( )
Always	( )

24. Do you believe that your health and that of your children and/or family is:

	Yourself	Children/family
Very good	( )	( )
Good	( )	( )
Average	( )	( )
Bad	( )	( )
Very bad	( )	( )

25. Do any of your children have any physical or mental disabilities?

No children	( )
Yes, some disabilities	( )
No disabilities	( )

26. Have you had any dental care other than tooth extractions?

None	( )
Fillings	( )
Root canals	( )
Crowns or bridges	( )
Other: ____________	( )

27. Have you been or are you currently affiliated with the ISS, and how?

	Before	Now
No	( )	( )
Yes, as domestic service	( )	( )
Yes, other	( )	( )
Which: ________________	____	
________________	____	

28. Which birth control methods do you know or have you heard of? (S = spontaneously; R = recognizes). Which have you used or currently use?

	Knowledge			*Previous use*		*Current use*	
Methods	*S*	*R*	*No*	*Yes*	*No*	*Yes*	*No*
Pill	( )	( )	( )	( )	( )	( )	( )
IUD	( )	( )	( )	( )	( )	( )	( )
Injection	( )	( )	( )	( )	( )	( )	( )
Vaginal methods	( )	( )	( )	( )	( )	( )	( )
Condom	( )	( )	( )	( )	( )	( )	( )
Male sterilization	( )	( )	( )	( )	( )	( )	( )
Female sterilization	( )	( )	( )	( )	( )	( )	( )
Abstinence	( )	( )	( )	( )	( )	( )	( )

Other. Which? ____________________

29. How will you support yourself when you can no longer work or can no longer find work?

Companion	( )
Child/children	( )
Companion and children	( )
Family	( )
Pension	( )
Other. Which? ____________________	( )
No means of support	( )

30. DO NOT ASK: INTERVIEWER EVALUATION

Worker's physical, mental, and dental health is:

	Physical	*Mental*	*Dental*
Very good	( )	( )	( )
Good	( )	( )	( )
Average	( )	( )	( )
Bad	( )	( )	( )
Very bad	( )	( )	( )

PROTECTION OF THE ELDERLY WOMAN IN COSTA RICA

María de los A. Ramírez M.[1]

INTRODUCTION

Costa Rica has very special features: its small territory and pacifist tradition have enabled it to develop a universal social security system, within which comprehensive care of the elderly has become the most effective form of protection against the risks to which this population is exposed. This is not, however, a protection based on values and standards of other countries that differ from our own. Rather, it uses the most recent and reliable information to design and carry out actions and to project future necessities and demands pertaining to the daily reality of the elderly.

This paper presents the situation of the elderly woman in Costa Rica, with reference to sociodemographic, health, and social participation factors. It concludes with a model of care proposed in 1980 by social work students, which, with some revision, facilitates comprehensive care for the elderly woman through Social Security services. This model approaches the problem in different and complementary ways: individual care, promotion of social and productive organizations, and consciousness-raising in the community—elements that are clearly presented in the National Development Plan for 1986–1990 with regard to work with women.

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STATUS OF THE ELDERLY WOMAN IN COSTA RICA

Life expectancy at birth in Costa Rica for the period 1985-1990 is estimated at 74.1 years (Ministry of National Planning and Economic Policy, 1987). For women, it is considered to be 75 years.

The 1984 population census shows that 48.5% of persons older than 60 years of age are male and 51.5% are female. For the year 2000, the percentages will be 46.3% and 53.7%, respectively. The proportion of women in relation to men increases with age. This is because women marry men much older than they are, and because the male mortality rate is higher.

There is a trend among the elderly to move to urban areas. According to the 1984 census, 46.5% of the men and 57% of the women older than 60 live in urban areas.

It is estimated that 65.5% of the elderly have completed primary school; 7.55% have had some secondary school, and 3.4% have received university education.

A 1984 survey on the needs of the elderly in Costa Rica revealed that the percentage of women with no education is less than that of men: 22.5% and 26.1%, respectively (Raabe, 1987).

It is estimated that 45% of the men and 30% of the women older than 60 receive some type of pension. Most of the women over 75 years of age have never contributed to the system.

The percentage of women who live with a spouse or companion is smaller than that of men. Among those older than 80, the difference is significant: 54.1% of the men and 12.2% of the women live as a couple. "One out of every five women over 80 years of age lived alone in both geographical areas (rural and urban)" (Saenz, 1987).

"Among women, the proportion of widows is already relatively high before age 70, and it surpasses that of married women beginning at 74 years of age. After 75 years of age, almost two out of every three women stated they were widows" (Raabe, 1987).

Other studies (Calderón et al., 1984) indicate that women over 50 in urban and rural areas belong to extended families. It was determined in one of these studies that women at midlife live with young children, presumably because cultural models establish an image of the woman as a fragile, handicapped being, useful for household tasks—attitudes that "do not easily fit men" (Bodán, 1981).

Health problems are very frequent in the elderly population, especially among women older than 80 years of age who live in urban areas. It is estimated that 25% of them have impaired vision.

"Women in urban and rural areas are informed about medical services;

between two-thirds and four-fifths of urban women had been seen by a doctor" (Saenz, 1987).

According to data from the 1984 survey on the needs of the elderly, women were more self-sufficient in personal care, even those 80 years of age and older. However, 20% of the latter needed some assistance in personal grooming and did not have resources to obtain the necessary care.

Studies carried out with homemakers older than 50 years of age indicate that these women perceive themselves as relatively healthy, even though they say they are depressed. This is akin to the situation of a slightly ill person who dismisses disease symptoms as normal for her age. This situation increases the risk of loneliness and limits the possibilities for social integration.

Women's political and economic participation in national life has increased since 1950 due to the needs created by industrialization. Their incorporation into the labor force has grown from 14% in 1950 to 26% in 1988, a percentage that declines considerably with age. For women between 60 and 64 years of age, it was 14% in 1984; for those between 65 and 74, it was 7%; and for those over 74, it was 3%. Among those from 60 to 64 years of age in urban areas, the percentage was higher for women than for men. Only 8% of women older than 60 years of age considered themselves among the economically active population, and 12% stated they needed to work for economic reasons (Raabe, 1987).

It is interesting to note the data from a study (Calderón et al., 1984) according to which a little over one-third of the women had never had salaried employment. Sixty-eight percent of the rural women interviewed and 38% of the urban women stated they were opposed to women working, considering that homemakers wear themselves out with two jobs; 22% of the rural women believed that "a woman's place is in the home."

Even though the women revealed themselves to be against working outside the home, they said they were beginning to see it as a necessity. Sixty-eight percent of the urban homemakers indicated that they could achieve independence through work. Sixteen percent of the rural women said they needed to work to increase the family's income.

The traditional role of homemaker is not required of the elderly woman, as she is expected to have fulfilled that role while her children were growing up. Obviously, liberation from domestic work and social pressures permit her greater freedom to enjoy leisure time. The problem is whether or not she is socially prepared for this.

The elderly woman's participation in community life is limited. The results of various studies show that about 45% of women do not participate at all, not even in church affairs which are the most accepted. Most of those interviewed referred to lack of time and interest.

Interaction with neighbors is defined more in terms of what benefit can be obtained than the desire to share friendship.

Recreation is limited to sedentary activities within the home. The need for achievement in the women interviewed centered on domestic tasks, the traditional role assigned to the woman in our society. Though there is some evidence of a desire to assume new roles, this is not very significant in urban areas.

Other studies reveal that women over 60 years of age make greater use of community social services (Cespedes, 1987).

About 80% of those who participate in programs are women. The figures are different in homes for the elderly where most of the residents are men (57%).

Despite the fact that the organization of women has been accelerating, many government and private programs that encourage it do not respond to women's needs, nor do they permit women to break through barriers of subordination in our society.

The situation described has tended to improve as recently formulated policies have been implemented and as women of all ages become more willing to take advantage of educational programs and social services. These should be broadened to include comprehensive care activities with a definite preventive emphasis.

With regard to women from the less favored social strata, the noncontributory pensions system plays an important role in economic security. For this reason it must be fully incorporated into the policies of protection for the elderly woman, and must include economic resources, not only to provide pensions but also to establish programs of social rehabilitation.

COMPREHENSIVE CARE PROPOSAL

Based on a study directed by the author and carried out in 1980 by students of the School of Social Work of the University of Costa Rica with 250 homemakers older than 50 who attended the Dr. Solón Nuñez Frutos Clinic, the researchers formulated a project designed to prepare persons for old age (Calderón, 1980), which is summarized in Table 1.

As of 30 April 1980, the Dr. Solón Nuñez Frutos Clinic had a member population of 110,400 insured persons who reside in district 10, Hatillo, of the Central Canton of San José and in Canton X, Alajuelita, of the Province of San José. The community served by the clinic has three elderly daycare centers and a committee that is trying to create a similar service in another neighborhood. In addition, there is a club for older persons and a program called "School in the Community" that has been organized by 400 retired teachers who live in the area. Clinic staff and the

Table 1. Proposal for work with homemakers over 50 years of age and with the elderly, Dr. Solón Núñez Frutos Clinic, CCSS, 1980.

Time period	Type of project	Service	How carried out	Responsible institutions	Participants
Short term	Preparation for old age	— Medical care — Individual social care — Formation of groups — Supervised recreation — Information services — Occupational activities — Employment agency	Three afternoons a week homemakers will attend courses given by Clinic staff assisted by professionals from other fields.	— Costa Rican Social Security Fund — Ministry of Health — Ministry of Culture, Youth, and Sports — University of Costa Rica	Homemakers older than 50 years of age.
Medium term	Organization of homemakers	— Those mentioned above — Training of homemakers and volunteers — Mobilization — Organization — Projection to the community	Meetings with homemakers will be held once a week so that they may determine activities to be carried out.	In addition to the above-mentioned institutions, the National Headquarters for Community Development will be incorporated into this stage.	Homemakers of any age.
Long term	Creation of a daycare center	— All services above — Establishing a community company for self-management	Comprehensive care during the day. Transportation service.	All the above-mentioned institutions.	The elderly of both sexes who reside in the area.

staff of other public agencies and private organizations provide advisory services for these programs. What the social work students foresaw and planned eight years before has yielded significant results.

Thus, the health and social security services have taken shape as the most positive space for the actions that must be undertaken in order to improve the quality of life of these elderly women.

A proposal such as the one we have outlined, with the necessary revisions, would permit, among other things:

a) The detection and treatment of high-risk cases through a comparative diagnostic model, using a table to identify variables and indicators by functional area (Fandino Rojas, 1987).
b) The promotion of productive and social organizations through the intervention of professionals and volunteers who provide health and social security services, in close coordination with university community work programs and with the advisory bodies of small and micro businesses.
c) The participation of all public institutions and private organizations that develop programs and services for the elderly population.
d) Consciousness-raising in the community about its duties with regard to care of the elderly, and about the opportunities that must be given them in economic and social life.

In sum, the proposal facilitates work based on a diagnosis of the situation, by means of the three basic forms of social intervention: with persons, with groups, and with the community.

On the other hand, and with a longer range perspective, the government's interest in achieving "the real equality of women" will be translated into a series of programs and services that will encourage new roles in addition to the traditional one of homemaker. This situation will enable women at an early age to overcome the inequality of opportunities to which they have been subject and to meet old age with greater experience of social participation.

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THE AGING FEMALE POPULATION IN THE CARIBBEAN AREA: SOME ECONOMIC ISSUES[1]

Gloria L. N. Scott[2]

INTRODUCTION

As a result of improved health care and falling mortality rates in the Caribbean area, the proportion of elderly people is increasing. Given the already unbalanced sex ratio in some countries and women's longer (and increasing) life expectancy, women significantly outnumber men at older ages, the disparity increasing as age increases: there are twice as many women as men over 85 years of age. Their physical, emotional, and financial hardships increase with age, and elderly women in the Caribbean represent a class of the new poor.

Caribbean women are a very heterogeneous group whose members are separated by class and ethnic differences. Within each class a subculture of the overall Caribbean culture prevails, complemented by the particular cultural traditions of the ethnic group to which the women belong. These affect gender relations, family structure, economic opportunities, and women's status throughout their lives and have implications as they age. The level of economic development in each country and territory has had an effect on the occupational and domestic roles of women. Levels of development vary considerably, but women everywhere, especially poor women and older women, face special risks due to their disadvantaged situation.

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[1] This report is based on the paper by G. L. Scott, "Women, Health and Development in the Caribbean Region," prepared in February 1988 as the background paper for a PAHO seminar held in Trinidad and Tobago, 4-6 May 1988.

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The elderly population will become increasingly significant as a group to be considered within overall development priorities, as both its numbers and its proportion relative to the overall population increase. The numbers will double in the next fifty years. In Barbados, for example, one in four persons will then be over 65, compared with one in ten today.

This phenomenon raises economic issues with implications for women per se, as well as for the total society and economy of each country. Several features of the economic situation of the countries in the Caribbean have implications for the phenomenon of the aging of their populations, and specific implications for aging women. Issues of aging are essentially of an interdisciplinary nature. However, this paper will separate some issues for discussion purposes. The first section discusses issues related to the economic situation, including structural adjustment, employment, and migration. The next looks at features of the aging female population, including family and household structure, education, and health. The final section suggests some additional issues that should be addressed, including information, legislation, training, and a role for nongovernmental organizations.

THE ECONOMIC SITUATION

In the past decade, sometimes referred to as the "lost decade" (Economic Commission for Latin America and the Caribbean, 1987), development in the Caribbean as elsewhere has been constrained by the worldwide economic recession. Thirty to forty percent of export earnings are being used to service debts. Recession in donor countries has dramatically reduced the availability of financing from those sources. The resultant lack of resources to invest in human development has threatened the well-being of various population groups.

There has been serious deterioration in the indicators of the quality of life—reduced GNP per capita, high levels of unemployment, and increasing prices of food, drugs, and essential consumer goods. In addition, social expenditures have not been maintained at previous levels in real terms and are not keeping pace with population growth. Any adjustments made have tended to be towards improved efficiency and reduced spending, ignoring the human dimension. Most countries do not yet know the full extent of the decline in spending for human development, nor have they yet examined the immediate or long-term human impact and societal cost of the policy changes that have been made in response to the economic crisis. Worldwide, figures indicate large disparities between men and women in their command over resources. The hours put in by women in paid work and household maintenance activities far exceed those of men, but throughout their working lives women tend to earn less than men. There are clear indications of women's propensity to spend most of any excess income they obtain on their families. Thus, they can accumulate less property than men and so have limited resources with which to provide for their old age. As they age, the proportion of women among the assetless poor increases. It is for this reason that there is need for concern regarding any deterioration of economic conditions that would further aggravate these tendencies. The less able women are to provide for themselves, the more will they be a burden on society, due to increasing dependence on their families, their communities, and the state.

The Third Meeting of Commonwealth Ministers responsible for Women in Development (held in Antigua in 1985) examined some of the specific implications of the economic crisis for women—changes in income, in prices, and in working conditions in both paid and unpaid work. They stressed that because of their responsibility for household management, women bear a disproportionate share of the difficulties of adjustment. It has been suggested that if women's position before the crisis was difficult, it is now infinitely worse. There are now more poor women, and their degree of economic, social, and political poverty has increased. It is possible that the present crisis of social disinvestment is being financed principally from the resources of a "social fund" provided by the efforts of poor women, which make it possible for almost one-third of the population of the area to survive (Cornia *et al.*, 1987, p. 12).

Many Caribbean governments have had to undertake structural adjustment policies to cope with the economic crisis, and these too have specific implications for women. An example is the increase in prices of consumer goods and services through means such as the removal of food subsidies, as in Jamaica, or drug subsidies, as in Trinidad. Restrictions on imports and devaluation of exchange rates increase the prices of imported goods (Glewwe, 1988, p. 5). Structural adjustments also affect employment of household members, most immediately through reduction of public sector employment. The reduction in government expenditures on social services has serious implications for the employment of women, governments having been the principal employer of female labor in the provision of health, education, and social welfare services. Reduction in provision of public sector services, including transfer payments, makes it more difficult for women to gain access to them. In Jamaica, overall real government expenditure fell by 29% between 1981–1982 and 1985–1986.

The social services budget was cut even more, with its share of total expenditure falling from 31% to 24% over the same period (World Bank, 1988).

Structural adjustment policies have also encouraged privatization of public sector activities, which has meant, among other impacts, the introduction of fees and deregulation of services, resulting in reductions in quantity, quality, and availability to the poor. It has been noted that in some cases the private sector provides services more cheaply than the state. This is achieved, in the case of private cleaning contractors, for example, by reducing labor costs through the employment of female cleaners at wages and employment conditions inferior to those offered by the government (Commonwealth Secretariat, 1987, p. 7).

A serious cost of high birth rates and rapid population growth in the Caribbean in the past few decades involved the patterns of investment that were necessitated: resources that could have been used for raising standards were used to create facilities for the increased numbers, and more of the same infrastructure was provided instead of the installation of better and more productive equipment (Lewis, 1970, p. 23). As the population ages, previous priorities and allocations of investments geared to the demands of a young population become irrelevant. In countries where the birth rate has been declining for some time, for example France and the United States of America, many school buildings are unused. Generally, there is little flexibility in the allocations and no mechanisms for easy transfer from one use to another. In the health sector the priority investment (though not necessarily reflected in quantities of funds) has been maternal and child health, as part of the primary health care (PHC) strategy. Concern for women was related to reproduction. In the Caribbean, there are few facilities for health care of the aging population, and the additional facilities that are required now, and will be required increasingly in the future, are expensive compared to the costs of PHC. Given the gender ratios, the chief users of these services more and more will be women.

Financing of medical services for the low-income elderly in the United States represents some 9% of the federal budget (Jiménez-Castro, 1985, p. 88). Planning for the increasing number of the elderly is necessary. Especially in low-income countries such as those in the Caribbean, it is important also to monitor the proportion of the total population that this age group represents and the dependency ratio, to determine who is financing the care of the elderly. This issue, as in the United States, can be politically sensitive. Since women in general lack political power, the influence of older women on budget allocations is likely to be very weak.

In the Caribbean, Barbados has the highest proportion of population over 65 years, at 9.4%, a proportion approaching that of the United Kingdom. Because of emigration, the ratio of middle-aged to elderly people is 2.5 to 1 in Barbados, 3 to 1 in Jamaica, and 6 to 1 in Trinidad and Tobago. As the economic recession affects the standard of living of daughters and sons on whom the elderly depend for care, it will also have an impact on the resources they can devote to elderly parents. It is difficult to quantify the reductions in the flow of transfer income, but increasingly there are reports that family support systems are breaking down and that parents and older relatives are being abandoned. Evidence suggests that this may be more prevalent among some ethnic groups, correlated with economic conditions in those groups.

Employment

Turning now to questions related to employment, female labor force participation in the Caribbean has always been high, the majority of women being drawn into it by economic necessity. In Saint Lucia, the female participation rate exceeds that of males. For many reasons, including established customs and poor education, women tend to be overworked, underpaid, and denied access to high-income, high-prestige occupations. These circumstances affect women's health directly, as well as their ability to care for their families and provide for their own future.

Many women are involved in agriculture, and increased agricultural activity draws them in as a cheap source of unskilled labor, since they earn as little as a third of men's wages. The highest proportions of women workers are found in occupations such as domestic worker, nurse, teacher and clerical worker, shop assistant, and hotel service worker—all of which tend to be low paying, low-status jobs. Further, many employers run small-scale operations with rudimentary technology and substandard working conditions, such as those in the chicken processing industry in Trinidad. Women constitute the majority of workers in these occupations. In many of the "export zones," containing assembly line and textile industries, and in food manufacturing, large numbers of women are employed at the wages given to unskilled laborers (PAHO, 1985, pp. 46–49).

Unemployment among females is consistently higher than it is among the male labor force (frequently twice as high), and in a society in which a large proportion of households are supported by females, their unemployment has far-reaching consequences. One of these is the growing number of women engaged in multiple economic activities in the informal sector, about which there is very little information. What is clear is that they work long hours for low returns and utilize various survival strategies, including the labor of their children.

Other aspects of female employment have long-term implications for security in their old age and their ability to plan for their later years. Three of these are occupational health, employment-related pensions, and employment of older women. A recent seminar in the Caribbean sponsored by the Food and Agriculture Organization (FAO) confirmed that in the types of jobs that are opening up to women, they are being exposed to agricultural equipment, pesticides, toxic chemicals, and factory machines, many of which threaten women's health as well as the health of unborn children. Since consciousness regarding these issues is of recent origin,* there is no comparable information about the impact of poor occupational environments on older women that could be used to anticipate and plan for their health and other service needs. Governments have demonstrated an apparent lack of concern about the conditions of women workers in all economic sectors, whether trade, services, manufacturing, or agriculture (Bolles, 1986, p. 9). Barbados is considering a study of the health impact for women of new technologies being introduced into typically female occupations. Also, it is now recognized that many insecticides and similar products used in the household mainly by women are potentially harmful. Several of these products that have been banned in other countries, such as the United States, are exported to the Caribbean.

Many of the patterns of illness established by occupational conditions have long-term effects, e.g., rheumatism caused by working unprotected in refrigerated processing plants, damaged eyesight from doing piecework sewing in poor light, and general physical deterioration from excessively long hours of work. Many of these illnesses may remain undiagnosed and untreated, since women tend to ignore their own health. While they may not be crippling or immediately life-threatening, their cumulative effects limit the woman's physical capacity. By old age this limitation may imply the expenditure of public funds to help women who are unable to function independently and look after themselves.

With regard to employment-related pensions and other benefits, the characteristics of women's employment—informal sector jobs, self-employment, lack of job continuity, and work in unregulated industries as noted above—dictate that many women are unable to accrue pensions. Also, they are frequently ineligible for such job-related benefits as paid leave. After their working lives, these women will be totally dependent on personal savings, which even at higher economic levels are evaporating as inflation affects the real value of wages. Inflation has a second important impact, namely, when the pension is related to lifetime earnings, inflation erodes its value and, especially for older pensioners, the pension amount bears little relation to real costs of living. The issue of comparable worth has been raised regarding pensions. In Jamaica, for instance, where pensions for civil servants are calculated on the basis of salaries at retirement, persons who retired some years ago, when salaries were small compared with those today, are receiving much smaller pensions than recent retirees from the same post (UWI, 1980, p. 93). Widows are particularly affected by the inadequacy of the pensions.

Continued employment of the elderly in productive pursuits will help to reduce their financial dependency and promote their continued involvement in their communities. A combination of the need to work and interest in continuing to work is reflected in the increased labor force participation of females over 65 in Jamaica. In 1972, 22,900 women over 65 were in the labor force, compared with 31,800 in 1980. These figures exclude the large number of women working in the informal sector, who are not counted as part of the official labor force. In economies suffering from high unemployment, and in which various adjustment programs are being introduced that further reduce employment prospects, the creation of employment opportunities for older women presents a serious challenge.

In considering continuing employment for the elderly the artificiality of the concept of retirement age is revealed. Chronological age is not necessarily an indication of biological age, and a 75-year-old can be more physically and mentally competent than a 60-year-old, 60 being the age of retirement from government service in the Caribbean. In some fields in which women work, such as nursing, they can find employment as long as they wish to and are able to work, but usually not in the public sector. And although expected to work the same shifts, older women may be paid less than younger workers, not as a consequence of reduced productivity, but merely because they are old. For those women who worked in unskilled, manual jobs, some form of training combined with some seed money is usually a prerequisite for them to continue in productive work. Older women have been trained to do such work as setting up small production cooperatives to make preserves, to sew piece-work at home, and to work as teaching aides. The majority of the elderly women in the Caribbean do not receive pensions or other government allowances, nor regular financial contributions from private sources. An important aspect of providing economic opportunities for them is careful monitoring of how they live, what they know that they can turn into an economic activity, and how long they can continue productive work. It is also important to ensure that they have information about their entitlements, services that are available, and how to use them.

Migration

Migration has been a notable feature in the Caribbean. It has contributed to an unbalanced male/female ratio. In all the countries an increasing proportion of households are headed by women (36% in Barbados, 35% in Antigua). Emigration has also affected the ratio of the middle-aged population to the elderly. In Barbados and Jamaica, particularly, there are fewer people in younger age groups to look after the elderly. Further, emigration in the 1950s reduced the numbers that will reach retirement age in the next three decades. It bears repeating that the preponderance of male rather than family or single female migration leaves behind a higher than natural ratio of adult women to males. This situation should stabilize by the 2020s, when the generation produced by the high birth rates of the 1960s—for whom there were relatively few emigration prospects—will be reaching retirement ages. The concern, however, is that this cohort represents a bulge in the age pyramid, and that first education, then employment, and then services for the aged will have to be provided to these people during a period of limited economic growth.

In the Caribbean, around 15% of children are reared in "grandmother households," some of which are being affected by the economic conditions. A study in St. Vincent found that the majority of care providers to the children of migrants were women in their sixties. The stresses at an advanced age of coping with a difficult environment, making money stretch, and caring for children make life for both the children and nurturers less than ideal. Advantages to the situation are that the grandmother is not isolated from the young and that she remains a useful and important family member (Wiltshire-Brodber *et al.*, 1987). The households caring for the children of migrants tend to receive larger remittances than those without childcare responsibilities. Caribbean migration has given rise to the concept of the transnational family. Many of those remaining behind are dependent on their migrant relatives for basic subsistence, and that support saves many families from becoming dependent on the state. Recession in the countries that received the migrants, including those in the Caribbean, is affecting the flow of remittances, as many of those who migrated now find their costs of living increased and their earnings reduced.

Many of the migrants of the 1950s and 1960s who are now approaching retirement age are preparing for it by remitting funds for property purchases in their home country, to which they hope to return. In Jamaica, it has been noted that some funds sent to building societies have been used efficiently and in fact are contributing to national development. Unfortunately, some funds sent to friends and relatives have been misused. In this connection the general tendency toward abuse of remittances is worth noting. Of special concern here is the dishonest use of funds sent for older women, many of whom may be illiterate and/or mentally impaired.

AGING WOMEN

Discussed above were some ways in which selected economic phenomena affect women. In this section, the discussion will commence with aspects of women's situation, focusing on family and household situation, education, and health, and will proceed to some of the economic implications. The two sections obviously overlap, but it is useful to separate them for purposes of analysis.

Family and Household Situation

The high and increasing proportion of households headed by females in the Caribbean was noted above. This pattern has long been identified as a prevalent feature of Caribbean family structure, with the proportion headed by women being consistently about one in every three households. The highest proportion of head-of-household status is among single women, followed by women in common-law unions. Nearly seven out of ten single women in all the countries and territories are heads of households (Powell, 1986, p. 104). One factor contributing to this pattern is the emigration of males. A second is the family system that includes a high proportion of common-law and temporary unions, and, increasingly at older ages, a third contributing factor is the disparity of life expectancy between the sexes. Estimates have indicated that women-headed households may constitute between 25% and 40% of all households where the head is 55 years and older (United Nations, 1981).

Most men marry or form unions with women who are younger than themselves; since women live longer, a significant proportion of the older women heads-of-household are widows or women whose common-law spouses have predeceased them. Demographic characteristics thus create a pool of older women, including widows, who are unlikely to marry. Whether they have been long-term heads of households as single mothers or recent ones as divorced or surviving spouses, eventually their longer life span and the demographics of Caribbean societies mean that with increasing age more and more women will be on their own. Women more than men have lost a great deal of the economic and emotional security previously provided by kinship groups. Many women have to generate their own incomes. Frequently, such income is irregular, and in some rural areas survival depends on barter and various informal types of cooperation.

There is a correlation between the economic situation of the household and the gender of its head. Among the poorest of households there is a preponderance of female heads, a fact that has long-term economic implications. Among the rural poor, households headed by women are more likely than those headed by men to have no children registered in school and to justify this situation by citing financial constraints. The need for multiple wage-earners in households headed by women appears to affect the extent to which their children—the future generation of workers—can take advantage of education services. Lack of effective access to education and other services, compounded by the disadvantaged economic position of the household, prejudices future generations, especially female children raised in households headed by women (Scott, 1987, p. 221).

The most obvious economic implications of the family and household structure as it relates to aging women would include those to which the poverty/deprivation of households headed by women give rise: for the women themselves, the likelihood that they cannot provide resources for their older years when they are unable to work, and for the females in their families, decreased opportunities due to limited access to education, which will now be discussed.

Education

Education is among a group of characteristics that affect the speed and efficiency with which individuals respond to new opportunities, health and environmental services, and other factors affecting physical well-being (Birdsall, 1985, p. 16). Education opportunities in the Caribbean have been expanded in recent years, and younger women have had greater access to education than older women. In a survey in Barbados, Antigua, and St. Vincent, many women over 40 years of age had had limited educational opportunity and appeared resigned to their educational deficiency. Many older women stressed the economic hardships that they and their families had experienced in their youth, and many had entered school at later ages than the younger women in the study. The older women as a group were much more likely to have had only primary education (McKenzie, 1986, p. 66). In 1970, 10.5% of Jamaicans had received secondary education, but persons over 60 represented only 3% of that total. While the education systems in the Caribbean never openly discriminated against females, social and cultural limitations on girls had a discriminatory effect.

With the expanded education system, the decline in overall illiteracy in the area has been more marked for females—75% of the women in every country are literate or have been exposed to some level of education. Greater participation of female students at both primary and secondary levels has been encouraged, but segregation of schools by sex and different curricula for boys and girls, which had their origins in church involvement in the education system, perpetuate a sex bias. While in some countries educational attendance and performance of girls at secondary and primary levels surpasses that of boys, this trend is reversed at the tertiary level, though the proportion of females at that level is increasing. The majority of females still choose areas of study that are extensions of women's traditional work in society.

The societal benefits of educating women have been documented (World Bank, 1980). Better-educated women will be more productive workers and better mothers. Educational attainment of children correlates with the education level of their mothers. Families are better nourished and their general welfare improved the more education the mother has received. It thus appears that if women have opportunities for education, within the limits of the economic system, their chances of being able to provide for their old age improve. As life expectancy increases in the area—as it did by 20% in Trinidad and Tobago and 24% in Guyana between 1950-1955 and 1980-1984—the productivity-diminishing impact of women's limited education operates over more years of potential life. This aspect is usually ignored in cost-benefit studies of the value of investments in education.

Health

In 1984, for the first time, Caribbean Ministers of Health considered the problems of the aged as a group with specific health care needs. Although women face the same health problems as men, they suffer from many additional health risks due to their lower socioeconomic status, their limited access to basic resources, the time and energy demands of a double workday that combines household maintenance and economic production, and the physical demands of reproduction (Pan American Health Organization, 1983, p. 16).

The elderly are generally less healthy than the young, make greater use of health services, and generate higher health care costs. This necessitates more funding and more efficient use of existing resources. Also, since health is only one element of well-being, a wide range of policies/programs in other sectors is required to ensure that the aged can live out their lives in dignity and comfort without representing an excessive cost to society (Anzola-Pérez, 1985, p. 20). Women have a crucial role in relation to health. Their own health is intimately linked to that of their children and families, for whom they provide front-line health care and a household environment that may or may not be conducive to good health. Many complex factors contribute to women's health, some of which are directly related to health and some to attitudes and institutional structures that limit the economic and social progress of women.

As noted above, a woman's chronological age is not necessarily an indication of her biological age. Older women's health reflects the cumulative impact of stressful conditions, genetic influences, endocrine changes, lifestyle, and adverse social treatment experienced throughout life. Several of the diseases afflicting older women require expensive treatment facilities, drugs, and equipment and often institutional care. These diseases include malignancies (some countries of the Caribbean have incidence rates of cervical cancer that are the highest in the world), diabetes, hypertension, and broken bones. Because of limited time and financial resources, inaccessibility of health services, and lack of transportation, these diseases often remain undiagnosed until so late that their treatment becomes very expensive, if possible at all. Many women never seek health care for themselves, and poor nutrition complicates their health status.

Many of the poor in the Caribbean lack sufficient purchasing power to meet their daily nutritional requirements. Because food accounts for a large portion of household expenditures, the removal of subsidies on food prices has particularly adverse effects on the poor, and on older women among them. Many have been forced to reduce food expenditures and possibly nutrient consumption in response to higher food prices and reduced food subsidies (Leslie, 1987, p. 29). Many can no longer afford to purchase drugs such as those used to control diabetes or hypertension. In Jamaica, the average five-person household with two wage-earners could only meet half their minimum dietary needs in 1984. The government introduced a food aid scheme in 1984 that would protect the elderly and the very poor. There have been administrative problems with the scheme, and the real per capita value of the funds transferred has been sharply eroded by rapid increases in food prices (World Bank, 1988, p. 22).

Although it is a growing problem in the region, relatively little attention is given to women's mental health, including covert depression and psychological maladjustments. It is particularly important to look at the physical outcomes of mental health and stress and their costs to society. A manifestation of the breakdown of family support is the increasing number of mildly maladjusted females who are now vagrants. Women more than men appear to suffer from loneliness, isolation, apathy, and depression, which combine with transportation difficulties to discourage them from making use of health services.

OTHER ISSUES

The preceding sections have discussed aspects of the interaction between women and the socioeconomic situation in the Caribbean, suggesting implications for older women. The issues have been separated for convenience, but it should be recognized that they constitute a continuum, each having consequences on the other. Women's issues cannot be discussed meaningfully in isolation, but rather should be seen as part of an overall strategy that takes account of intersectoral and intergenerational links, as well as the complementarities between women's issues and the situation, roles, and activities of men.

Information about the physiognomy of aging and its repercussions on national and international economies is scarce, and much of that information is not disaggregated by gender. Thus, little is known about the ways in which behavioral and socioeconomic factors interact with biological ones to affect the situation of women over the course of their lives. The highly aggregative nature of data on the composition of social expenditure, for example, limits an understanding of the impact of social expenditure cuts on the poor. Detailed information on the focus and efficiency of expenditures (including information separated by gender and age) is needed for an accurate assessment (International Monetary Fund, 1988).

Interrelations between the economic situation in Caribbean countries and poverty, especially among women, have been mentioned. They raise questions regarding the future of those segments of the population, and about whose efforts will support them if they are unable to support themselves. In most countries, the alternatives to family support are very limited. Many older people, including older women, fall outside the provisions of the public sector (Bahamas and Jamaica have set up Councils on Aging to serve as links between the elderly and the government). In many of the countries, the private sector has been playing an increasingly important role. Many nongovernmental organizations and women's organizations are providing services such as meals on wheels. Golden age clubs are trying both to improve the quality of older women's lives and to ensure their continued participation in the community. Private industry has established foundations for community development, for example the Grace Foundation in Jamaica. Traditional organizations such as Friendly Societies in Jamaica have been important in assisting poor women to save for their old age. The University of the West Indies (UWI) and the Bureau of Health Education have been holding workshops and making other efforts to increase community awareness and support.

Many laws in the Caribbean either discriminate overtly against women or overlook the need to provide specific protection for them. In addition, many women are ignorant of beneficial provisions of existing laws. Among the areas identified as needing legal revision are laws governing inheritance, property taxes, and registration of nursing homes. Again using Jamaica as an example, the Widows' Pension Act, 1971, discriminates against widows whose husbands died before 1962; the National Insurance Scheme makes no provision for the many women who were over-age when it began.

UWI has introduced the study of geriatrics at the undergraduate level. Issues related to women's role in development have recently been incorporated into postgraduate economics. The Social Welfare Training Center has a program on aging, as does the Department of Social and Preventive Medicine. With collaboration between these programs and others, the human resources needed to deal with the issues discussed above are being prepared. How this training relates to the particular needs of each country and the possibilities of duplication, overlap, and other inefficiencies should be examined, as should the question of the time lag between program initiation and the availability of trained workers.

The Nairobi Forward-looking Strategies for the Advancement of Women emphasized the need to start preparing women early in their lives to face the consequences of longer life expectancy. They also focused attention on the need for investigations that would yield information that might help to slow down the process of premature aging caused by a lifetime of stress, excessive workload, malnutrition, and numerous pregnancies (United Nations, 1985, pp. 68–9). Attitudes and perceptions of both males and females of all ages, as well as the system of social organization, intervene in policy formulation and implementation and lead to unanticipated consequences that, in turn give rise to economic costs that frequently fall hardest on women. Discrimination against women and economic disadvantages are harmful not only to women, but affect society at large (Scott, 1985). This paper has attempted to focus attention on the cumulative impact of these factors on older women.

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WOMEN AND OLD AGE: STATUS OF THE ELDERLY WOMAN IN MEXICO

Esther Contreras de Lehr[1]

DEMOGRAPHY AND AGING

The twentieth century has seen important advances in the control of perinatal and infant mortality, reduction in the birth rate, and the control of infectious diseases, as well as improved nutrition and basic sanitary care. The results have been a larger number and proportion of people reaching more advanced ages.

Mexico's demographic structure is characterized by a young population: 56% of the total population of almost 70 million inhabitants was younger than 19 years of age in 1980. However, it is estimated that by the year 2000 this segment of the population will decrease to about 30.5%. Furthermore, it is projected that the elderly population (60 and above), which in 1975 was more than 3 million persons, will have increased by 114% in the year 2000; this means that by that year there will be almost 7 million elderly people, and by the year 2025, 12 million. The country currently has more than 4 million people 60 and above, who represent almost 6% of the total population.

It is important to point out in this context that the country's population policies have been a determinant in the aging of its population, since a considerable reduction in the growth rate has been achieved. It has dropped from 3.5% in the 1970s to 2.1% at present, and it is expected to be only 1% by the year 2000.

One fact that requires special attention is the remarkable number and proportion of elderly women in relation to the male population. This phenomenon occurs in almost every nation in the world. For example, in 1980, in the developed countries there were only 66 men of 60 and above for every 100 women, and in the developing countries the ratio was 93 men for every 100 women. This disproportion is even more pronounced at older ages. In the age group of persons 70 and above, there were only 58 men for every 100 women in the developed countries, and 86 per 100 women in the developing countries.

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[1] Helpage International, Mexico.

Mexico, the same as other countries of the world, has a preponderance of females in all of the older population groups (Table 1). Up to 1985 there was a 3% difference between the total number of older men and women; by the year 2000 this difference is expected to increase to 10%.

This widening gap is partly due to the fact that life expectancy at birth is longer for Mexican women than for men. It increased from 65.5 years in 1975 to 68 years in 1985 for women, while for men it increased from 61.5 in 1975 to only 64 years in 1985. It is estimated that by the year 2000 life expectancy for females will be 72 years, while for males it will be 68 (CONAPO [National Population Council], 1982, p. 29).

Female longevity is reflected in the large number of widows. In 1980 there were only 374,421 widowers while there were 1,349,934 widows, that is, the number of widowers was only 28% that of widows.

These demographic considerations shed some light on the quantitative dimension of aging in Mexico, and they especially invite reflection on the destiny and future of elderly women.

DETERMINANTS OF AGING

There are several determinants that influence the aging process:

- Biological—This factor includes the individual's development and physical constitution, her clinical history, her current state of health, and her expectations in this regard.
- Social—Society's image of aging and the attitudes reflected in the older person's social milieu decisively influence her behavior and self-image.
- Economic—The economic situation is also fundamental in aging, since the range of activities and interests of the older person, as well as her personal care, health, and general lifestyle, will depend on the economic resources available.
- Historical/cultural—The historical events that surround the individual, such as wars, catastrophes, and economic crises, affect the older person's participation in the labor force. Whereas in times of war the

Table 1. Life expectancy, by age and sex, Republic of Mexico, 1980.

Age	Male life expectancy (years)	Female life expectancy (years)
At birth	63.6	67.4
At 5 years	64.2	67.6
At 20 years	50.3	53.6
At 40 years	33.1	35.6
At 60 years	18.0	19.3
At 70 years	11.9	12.6

Source: Contreras de Lehr, 1984, p. 44.

elderly are integrated into the country's economic process, there is a tendency to cast them aside during times of economic crisis, giving preference to younger people. In Mexico, for example, the patterns of aging of the revolutionaries were different from those of persons in the post-revolutionary period, due to differences in their historic situation.

Since multiple factors influence aging, it is not simply chronological age that determines behavior and personal experiences in old age. Therefore, the aging process must be considered in terms of *individuals* rather than the whole population, leading to different models for aging that vary a great deal.

Biological Determinant in Female Aging

Medical science predominantly seeks to explain the health problems of elderly men and women by considering the biological/physiological changes or pathologies that affect human life. The advances achieved under this approach have basically been aimed at curing diseases already present in the individual, while all social aspects of the problem and its solution are relegated to a secondary level.

This view stresses physiological changes for the worse, meaning the progressive degeneration and atrophy of systems, with an emphasis on the deterioration of the sensory functions (Guerrero, 1981, pp. 23–31). Under this model of deficiency it is asserted and generalized that all functions and capacities deteriorate with advancing age. In this context, a woman is considered a biological reproductive entity and her role is limited to that arena. Thus, when she reaches menopause, she becomes old.

However, the intervention of other disciplines in gerontology and the results of multiple research studies have made evident the limitations of this model. It has been demonstrated and confirmed that there are both inter- and intraindividual differences in aging that are mainly determined by the person's social and economic circumstances. In accordance with the multicausal model, a woman's status in the family, at work, and in society is the principal factor that conditions her overall health (Teixeira, 1986, p. 6).

Information on women's health is scarce, but this problem is even greater in the case of elderly women, since data is not disaggregated by sex or age. An analysis of mortality rates by sex (Table 2) shows that the general mortality rate is higher among men than among women. This tendency is partly due to both the higher incidence of deaths in young boys than in girls (from infectious and respiratory diseases) and the high incidence of male deaths linked to the social milieu and work (from respiratory disease, diseases of the digestive tract, accidents, violence, poisonings, and mental disorders).

On the other hand, mortality rates are higher in women for diseases related to longevity (circulatory diseases, tumors, neoplasms, and endocrine, nutritional, and metabolic diseases).

These tendencies will probably change as more women join the paid work force and bear a double work load; that is, their morbidity and

Table 2. Mortality rates for leading causes of death, by sex, Republic of Mexico, 1976.

Cause of death	Rate per 1,000 women	Rate per 1,000 men
All causes	6.63	8.15
Infectious and parasitic diseases	1.28	1.42
Respiratory diseases	1.26	1.42
Circulatory diseases	1.12	1.09
Ill-defined conditions	0.70	0.72
Tumors and neoplasms	0.44	0.34
Accidents, violence, poisonings	0.35	1.38
Nutritional and metabolic glandular diseases	0.33	0.27
Diseases of the digestive tract	0.31	0.56
Diseases of the genito-urinary tract	0.15	0.14
Complications of birth and pregnancy	0.15	—
Diseases of the nervous system	0.08	0.10
Diseases of the blood	0.08	0.07
Mental disorders	0.01	0.08

Source: Secretaria de Programación y Presupuesto, 1980, pp. 290-91.

mortality will be influenced by both job-related risks and the effects of working in the home.

The epidemiological picture for the age group 65 years and over (Table 3) shows both diseases typical of the industrialized countries (heart and cerebrovascular diseases) and deaths caused by diseases characteristic of the less developed countries (pneumonia and infectious and intestinal diseases).

These diseases are probably accentuated in women, as is already the case in the developed countries, so that it will be necessary to develop health programs to prevent them and to reduce their incidence among females.

Social Determinant in Female Aging

The social system is a determining factor with respect to one's self-image and experiences. "Getting old" frequently becomes a burden for the individual due to society's stereotyped expectations of behavior. Even though an older person may feel completely capable, society has other expectations to which he or she is obliged to adapt.

Adaptation to behavioral patterns decreed by society limits the aging individual; it may mean renouncing habits to which he or she is accus-

Table 3. Number, rate, and rank order of ten leading causes of death in persons 65 years of age and over, Republic of Mexico, 1981.

Cause	Rank order	Deaths	
		Number	Rate[a]
All causes		134,846	5,322.14
Pulmonary circulatory diseases	1	18,299	722.23
Cerebrovascular disease	2	10,034	396.02
Diabetes mellitus	3	8,509	335.83
Acute myocardial infarction	4	7,857	310.10
Pneumonia	5	7,685	303.31
Bronchitis, emphysema, and asthma	6	6,167	243.40
Infectious intestinal diseases	7	4,931	194.61
Cirrhosis and other chronic diseases of the liver	8	3,681	145.28
Nephritis, nephrotic syndrome, and nephrosis	9	3,660	144.45
Other accidents, including delayed effects	10	2,695	106.37

Source: Secretaría de Salubridad y Asistencia, 1981, p. 26.
[a] Rate calculated per 100,000 population.

tomed. Furthermore, the roles that society decrees for elderly persons contribute to the formation among young people of a negative attitude toward aging.

Studies on stereotypes and attitudes regarding old age, by both the mass communications media and individuals, show that old age has a generally negative image in the industrialized countries. Although studies on the subject in developing countries are few, the image of old age is not so negative because the elderly still play an important role in the family and in society, since they continue to be the medium through which knowledge and experiences are transmitted.

However, our society is much more generous in its attitude regarding male aging than it is toward female aging. Physical attractiveness counts more in a woman's life than in that of a man, and beauty is particularly identified with youth (Sontag, 1982, p. 12). The "ideal woman" is described with adjectives such as "pretty, nice, attractive," but also with regard to characteristics such as loving and maternal (Lehr, 1980, p. 4), while masculinity is identified with capability, independence, and self-control—qualities not diminished by the loss of youth and that can actually increase with age and experience.

Society's image of the female is most positive between 20 and 45 years of age, but as she gets older it becomes more negative. In a study in Mexico on how people viewed old age (Contreras de Lehr, 1984), an analysis of the differences between sexual stereotypes showed that the image of the elderly male is more positive than that of the woman at the same age.

This image also has a negative influence on the woman. Society limits her behavior in old age, and a discrepancy emerges between what a woman of this age wants to do and what others expect her to do. She is normally expected to be more passive, to show less initiative, to be sickly and asexual. These expectations act on her until she ends up perceiving herself in that way. Thus, one is not only as old as one feels, one also becomes as old as society decides. Gerontology has recognized that *social determinism* is a decisive factor in aging.

Economic Determinant in Female Aging

Data that would allow an analysis of the economic status of the elderly female are scarce. However, for several reasons it can be affirmed that her situation is precarious and that this group is among the "poorest of the poor."

The social security system in Mexico is still limited, since it normally benefits only salaried individuals and workers in the public sector. The self-employed and the agricultural population are excluded from this system. Since a large portion of the population is not covered by social security, it can be assumed that a considerable number of elderly persons work until they are no longer able to do so, and that this situation probably occurs more frequently in rural areas.

Data from the Tenth General Population and Housing Census of 1980 show that the proportion of elderly persons who are still involved in some productive activity is relatively high: 46% of the population 60 years and older is still economically active. A large majority of the elderly men (74%) were involved in some productive activity, while only 20% of the elderly women were considered to belong in this sector of the economy.

Although the economically active population is counted as being mostly male in the rural areas, many activities carried out by elderly rural women are not recorded in censuses or statistical summaries because their work is considered unpaid domestic work.

Domestic work is one of the main activities for the majority of these women for their entire lives. Elderly women are especially vulnerable because they depend on the economic support offered by the family. This situation is even more evident in the case of widowed or single women, since, in the absence of their own or their husband's pension, they must depend completely on the support of relatives or close friends to survive.

For some elderly rural women, their children represent security in old age, but the constant migration of young people to urban areas means that many elderly women must remain alone in the countryside and continue to do whatever work they can in order to subsist.

The main work activities for elderly women are in agriculture, livestock raising and fishing, and personal and community services. Very few women of this age group work in other sectors.

Finally, it should be mentioned that elderly rural women suffer more illnesses than men and that their state of health is more impaired for their age, due to a lifetime of poor nutrition and the strain of pregnancies during their youth.

Historical/Cultural Determinant in Female Aging

Historical events, or the times in which an individual grows up, also determine how one ages. For example, the cohort that participated in the Mexican revolution had less access to the educational system, while those who were born 20 years later lived in a different historical/cultural moment, which included the educational and economic reforms of Cardenas (Contreras de Lehr, 1980, p. 592). Likewise, the current cohort of chil-

Table 4. Literacy in population, by age group and sex, Republic of Mexico.

Age group (years)	Literate						Illiterate					
	Total		Male		Female		Total		Male		Female	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
60–64	732,683	(20%)	389,895	(20%)	342,788	(20%)	382,463	(11%)	151,967	(8%)	230,496	(13%)
65 and over	1,491,607	(40%)	774,387	(40%)	797,220	(45%)	1,069,513	(28%)	430,289	(22%)	639,224	(36%)
Total	2,224,290	(60%)	1,164,282	(60%)	1,140,008	(65%)	1,451,976	(39%)	582,256	(30%)	869,720	(49%)

Source: Secretaria de Programación y Presupuesto, 1984.

Table 5. Literacy in female population, by age group, Republic of Mexico.

Age group (years)	Total women	Literate		Illiterate	
		No.	(%)	No.	(%)
40–49	2,566,432	1,851,158	(72%)	715,274	(28%)
50–59	1,684,479	1,115,111	(66%)	569,368	(34%)
60–64	573,284	342,788	(60%)	230,496	(40%)
65 and over	1,356,444	717,220	(53%)	639,224	(47%)

Source: Secretaria de Programación y Presupuesto, 1984.

dren, in this era of computers and environmental contamination, will age under very different conditions than their elders did.

Most people who are now 60 years of age and older have an inadequate education, since the educational system was not very comprehensive during their youth. According to data from the Tenth General Population and Housing Census, 39% of the group 60 years and older was illiterate in 1980. Female illiteracy, at 49%, is especially notable, while male illiterates made up only 30% of the group (Table 4).

The lack of education among elderly women has also influenced their opportunities to work. Thus, it is not surprising to find that they are mainly involved in agricultural activities and domestic services. However, educational opportunities have improved considerably for younger women. In Table 5 it can be observed that in the age groups of persons 40 to 49 and 50 to 59, female literacy is significantly higher than in the age group of 60 and over. This fact will probably be reflected in better living conditions and more satisfactory work opportunities that will allow women in these age groups to age with greater dignity.

CONCLUSION

In summary, the aging of the population is a recent phenomenon in Mexico. A fact that requires special attention is the marked—and increasing—number of elderly women in relation to the elderly male population. Old age is not considered to be only an irreversible biological process, but rather a process determined by social, economic, historical/cultural, and ecological factors. All these factors influence and determine the forms and patterns of female aging.

The data provided in this presentation show that elderly women live in precarious conditions. A lack of education and the absence of social security for the majority of these women who have dedicated their lives to unpaid domestic work are indicators of this group's vulnerability.

This population segment has specific needs in the areas of health, housing, nutrition, and so forth. Therefore, studies aimed at acquiring comprehensive knowledge of their situation are critical if the needs of elderly women are to receive adequate attention, particularly on the part of health and social welfare programs.

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BIOPSYCHOSOCIAL ASPECTS OF THE VENEZUELAN POPULATION 60 YEARS OF AGE AND OLDER

Haydee Morazzani B.[1]

Venezuela's demography is characterized by a burgeoning birth rate that has produced a population in which 75% of the people are currently younger than 30 years of age. This fact explains why its political structure is conceived for the young, productive, dynamic man, and not for the elderly. Though the country must address the demands of a mostly young population, it must also meet the equally important needs of persons 60 years of age and older.

Without previous studies on the biopsychosocial characteristics of the elderly, private and government institutions and agencies responsible for this sector elaborate policies that are not tailored to the sector's real needs. These institutions provide many services, but their efforts are almost always ineffective, uncoordinated, isolated, and insufficient to cover the numeric demand. Efforts to provide gerontological/geriatric care, although based on empirical assumptions and deductions, now require studies.

The Ministry of the Family, through its Sectoral Headquarters on Care for the Elderly, considers it essential to study the biopsychosocial aspects of the population aged 60 and older, in order to determine the needs of this age group and, as a response to their basic requirements, draw up policies and establish activities to help them solve their problems. The Minister's full support and her desire to give a solid foundation to the new Ministry and its gerontological/geriatric area made this project possible.

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[1] Sectoral Director General, Care for the Elderly, Ministry of the Family, Venezuela.

Our goal is to seek one of the objectives of the General Sectoral Plan on Care for the Elderly (Third Age), so that this knowledge will allow us to establish policies and programs that will better meet the basic needs of the elderly.

In recent decades, rapid and confused sociocultural changes have destabilized the traditional Venezuelan structure.

- An accelerated population growth is the result, among other things, of a progressive increase in life expectancy at birth along with a flow of immigrants. In the census analysis[2] we find that more than 900,000 people are older than 60 years of age, making them a significant group that can no longer be ignored.

  This population growth helped cause the breakup of social stratification, weakening the basic unit—the family—and generating a series of concurrent problems regarding housing, nutrition, work, education, health care, etc.
- The family experienced profound changes, losing importance and splintering due to demographic shifts, especially the migration from the countryside to the city and the emergence of new urban centers—these shifts were consequences of a search for a better standard of living.
- Economic imbalances due to an unequal wealth distribution left many persons in abject poverty, without sources of work, and living in overcrowded conditions in marginal areas.
- The population increase has led to a serious housing problem that the state is determined to resolve. The slums which have emerged around the cities seriously endanger the lives of residents, since the dwellings are built on unsuitable ground (prone to landslides, in creek or riverbeds, or areas subject to floods), near garbage dumps, near open sewage, etc. Poverty, as far as housing is concerned, translates into a proliferation of shanties and dwellings built with cheap, flimsy materials (sheet metal, boards, cane, straw, cardboard, stones, etc.), which are cramped, poorly ventilated, and lack such basic services as water supply, electricity, running water, sewage, etc. These housing conditions, combined with an absence of any housing plan, leave these neighborhoods without any infrastructure, since they were not planned as housing developments. The inhabitants' low income, inadequate nutrition, and lack of education render them more vulnerable to disease.

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[2] 1981 Census Projection for 1987.

Old age is a complex biological process characterized by progressive and irreversible transformations over time. The aging process is determined, in part, by the individual's genetic inheritance and, on the other hand, external factors that are physical, environmental, and sociocultural.

Aging is expressed in a series of characteristic changes in personal appearance, tissue alteration, and decreases in the functional reserves of the organs that make the organism more susceptible to internal and external factors, with a consequent decrease in the capacity to adapt to frequent or repeated changes.

The problems of the woman 60 years of age or older emerge when the basic needs of life, both organic and psychological, are not met. All human beings need security, family, affection, appreciation, and respect for their development and self-fulfillment, and aging persons are no exception. When a woman ages beyond 60 years, she still needs a balanced diet; good nutrition is one of the most important factors mediating in the health of the elderly, which along with adequate clothing, personal hygiene, and adequate and sanitary shelter satisfy her basic needs.

With time, a woman experiences a progressive physiological regression as well as diminished functions and capacities. Her gait is slow and unsure, her vision has weakened, her hearing is impaired, her mind has lost some of its alertness, and her memory now struggles to bring back the past.

As time wears away her life, others (the family, institutions, or the state) must collaborate to help the elderly woman satisfy her needs and solve her problems in the best possible way.

The security and stability offered by the family constitutes the foundation on which the personality is formed, consolidated, and maintained throughout all ages; thus, when material and spiritual conditions in the family break up or dissolve, the elderly woman's personality suffers. The love, respect, and consideration of her own family, especially, will help her cope with the pressures of her aging and the changes she must undergo.

In Venezuela, the essential needs of old age are not covered in a real, positive, or satisfactory way; this is currently being studied. Attitudes must change in the community as a whole and in its institutions, and this change should involve families and, above all, the members of interdisciplinary teams responsible for comprehensive care for the elderly. Beginning in 1986, Venezuela has set two fundamental objectives for itself: economic growth and social justice.

Economic growth rests on making use of our capability to create wealth and generate internal and self-sustaining processes of development. Social justice seeks to equitably distribute the profits of growth and the increase in productivity, as well as extending political democracy to increase the community's participation in political, economic, and social decisions.

Since the family is considered the basic unit of society and the main promoter of the comprehensive development of its members, the family is both the object and subject of social strategy. In 1986 the Ministry of the Family was created; it is the governing, planning, and coordinating agency for the state's social policy regarding the family.

In an effort to correct the lack of direct and specific care, especially after the creation of the Ministry of the Family, the results of this study will be used to develop a geriatric policy better tailored to the real needs of Venezuela's elderly population, especially of women.

There are two reasons to correct this lack of direct care: first, the idea that the family is the basic creative unit of society, and that among its various generations, the elderly play important roles; and second, that this group is no longer a minority which only needs incidental attention. On the contrary, they require coordinated, permanent, and fair treatment. In fact, we now face a phenomenon of redistribution of the population in which there is a progressive increase in the number of elderly men and women.

STUDY DESIGN

This was a nationwide study that included different social strata and ethnic groups that make up our population, as well as both urban and rural areas.

In order to conduct this analysis, a questionnaire was developed that allows us to detect biopsychosocial needs of the group under study, as shown in the pilot test. The questionnaire has four parts: I. Identification; II. Characteristics of the Family Group; III. Physical and Environmental Aspects; IV. Diagnosis of the Biopsychosocial Aspects of the Elderly.

A stratified sample was used because this type of selection minimizes sampling error by having an exact design of the strata. Once the population projection was determined, the sample size was established as 10% of the population, or 99,649 persons, but due to technical problems in the field, it was fixed at 5%. Since we were able to classify persons by variable categories within each state entity (districts and/or parishes), we decided to consider population strata or sectors and to extract from them a stratified sample.

In order to form the *sample*, we had to designate the *universe* from which it was taken. For this purpose we took the Venezuelan population of 60 or more years of age, by sex and age according to the 1981 census, and projected it to 1987 by applying the corresponding formula.

In order to simplify data processing while maintaining the stratified sampling, in addition to reducing the surveyed population from 10% to 5%, it was decided to select a random sample equivalent to a stratified sample by distributing the size of the sample proportionally to the size of the strata. The sampling elements were selected by applying simple random sampling. After a review of the completed questionnaires, the data were put into the computer.

Data corresponding to two states were statistically processed, and these described the biopsychosocial aspects of the aged in Venezuela in these entities, factors that we consider extremely important for our geriatric policies and programs.

The population studies carried out in our country concluded with a taxonomy[3] of eight classes, where each one is representative of entities in similar conditions of poverty as defined by economic, educational, and housing indicators. We considered this taxonomy in carrying out our study; thus, the Barinas State Entity is representative of the class that also includes the Portuguesa State Entity. In the same way, the Mérida State Entity represents the class that includes the State Entities of Tachira and Trujillo in the taxonomy.

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[3] Multi-variant methodology to determine homogeneous areas of poverty in Venezuela, Ministry of the Family—United Nations Development Program—Critical Poverty Project, 86/004.

THE AGING WOMAN IN PUERTO RICO: PUBLIC POLICY AND PRIORITIES

Celia E. Cintrón[1]

Puerto Rico's demographic picture, perhaps more dramatically than that of other Latin American and Caribbean countries, shows a changing age structure especially marked by an increase in the adult and/or elderly population. These changes are attributed mainly to declines in the rates of birth, mortality, and migration. As is well known, migration has been characterized by a massive exodus of the young, mainly to the United States, and their return later, in adult periods.

According to population estimates made by the Board of Planning, Puerto Rico had a total population of 3,279,231 in 1985. Of these, 399,930 were persons 60 years old or older, which represents 12.2% of the population. As can be seen in Table 1, the largest proportions of older persons are found in the Regions of San Juan (17.0%), Bayamón (13.0%), and Ponce (12.0%).

Since male mortality is greater than female mortality, to speak of the elderly is, basically, to speak of elderly women. According to the 1980 census, there were 91 males for every 100 females of 65 or more years of age. This imbalance between the sexes is progressive, so that in the group we call the very old (75 or more years) the ratio of males is 84 for every 100 females, and when we reach 85 or more years of age, it becomes 71 for every 100. Life expectancy is more than seven years longer for women.

At present, Puerto Rico only ranks behind Japan, Sweden, and Canada

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[1] Gerontologist, Professor, University of Puerto Rico; Past Director, Gerontological Program, Graduate School of Public Health, Medical Sciences Campus; Director, Office of the Governor for Affairs of the Aging.

Table 1. Estimated population aged 60 and older, by region, Puerto Rico, 1985.

Regions	Total population	Population 60+ years	% of total population of region	% of all elderly in Puerto Rico
Aguadilla	215,385	25,693	11.9	6.3
Arecibo	330,093	42,482	12.8	11.0
Bayamón	511,087	51,674	10.1	13.0
Caguas	297,919	34,664	11.6	9.0
Carolina	421,320	40,971	9.7	10.0
Guayama	176,079	21,371	12.1	5.3
Humacao	183,135	21,748	11.8	5.4
Mayáguez	319,131	42,124	13.2	11.0
Ponce	399,332	47,853	12.0	12.0
San Juan	425,749	71,250	16.7	17.0
Total	3,279,230	399,830	12.2	100.0

Source: Board of Planning population estimates.

in life expectancy, and its life expectancy is very similar to that of the United States of America (Figure 1). This phenomenon involves role changes for the aging woman, since many of them become heads of family. In 1980, 22% of women 65 or older were heads of family, and 19% lived completely alone.

The census data show that while a high percentage of men had a wife at home, only 31% of women lived with their husbands; the rest were widowed, divorced, separated, or single.[2]

If we take into consideration the fact that the level of education of the elderly in general, and of the aging woman in particular, is currently low (averaging 3.8 years of schooling), this means an added difficulty for both sexes. The low educational levels will make the process of adaptation and change faced by this population more difficult. It should be pointed out, however, that this picture is changing, and that educational levels of future populations of the aged will be markedly higher.

The problems of this sector of our population, as noted by Carnivali, Velez, and Torres (1987), are not necessarily economic ones, although their incomes certainly are not large. Members of this group depend less

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[2] This picture leads logically to the fact that females predominate among the widowed. In 1980 there were 20,000 widowers and 65,000 widows in the 65 and over population, that is, the number of women was more than triple that of men; in relative terms, while only 17% of the males in this age group were widowed, 49% of the women were in this category. The same situation occurs with respect to divorce status, since men tend to remarry with greater frequency.

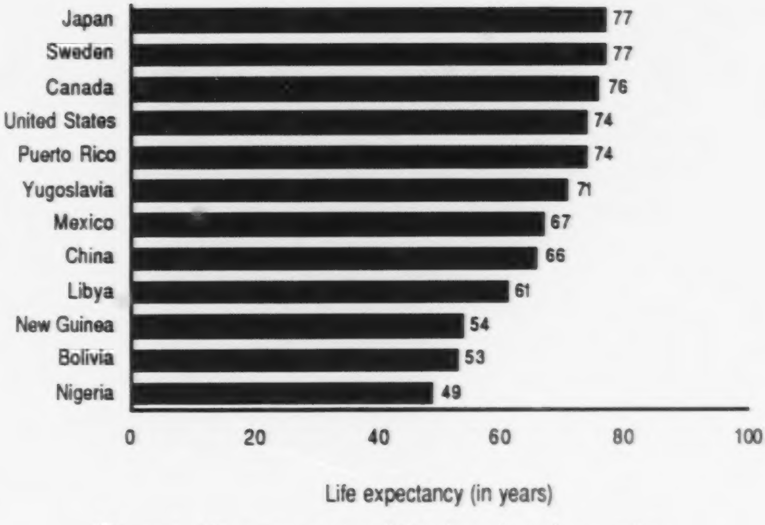

Figure 1. Life expectancy at birth for selected countries, 1987.

on the government than those of other population groups, and they are not burdens on their families as alleged by some.

What answer in terms of public policy and priorities has been given to the needs of this population which, as we have seen, is predominantly female?

We must admit that consciousness-raising in this respect has been slow, although in the last decade, and especially in the last four years, it has accelerated. Let us see.

Since the 1950s, the government of Puerto Rico has recognized the special needs of older persons and created a Commission on Gericulture under the Department of Health. As far as this is concerned, Puerto Rico was ahead of even the U.S. Congress, which approved the Older Americans Act several years later. The Commission became part of the Department of Social Services in 1962, in recognition of the fundamental importance of quality of life, in a social context, for the health and well-being of older adults and the elderly.

As our country's older population increased dramatically, the Commission could no longer carry out its added functions. For this reason, legislative and executive actions have been initiated in the last two years to strengthen the attention to and the planning of services for older persons. First, an Executive Order instructs governmental agencies to prepare specific work plans as a matter of policy. Shortly thereafter, two pieces of legislation emerged—one, Law 121, called the Letter of Rights of Older Persons; more recently, Law 68 of 1988, which created the Office of the Governor for Affairs of the Aging, which I have the honor to direct.

This recently created agency does not provide direct services; it is, however, a small but active organization with two principal missions: dynamic and strategic planning, and the coordination of current and future public and private efforts regarding the elderly.

Even the definition of elderly persons used in Law 68 is an innovation:

> (c) A "person of advanced age" or an "aging person" is an adult who is at that stage of maturity which is reached through the passage of time and as a result of experiences, but it should be understood that this stage does not necessarily begin at age sixty.

Specifically, the law points out functions, duties, or aspects, among them the following:

Functions and Duties

- To plan and coordinate with different public and private entities, programs, activities, and services directed to older persons, in order to ensure implementation of public policy according to conditions and restrictions of applicable laws.
- To provide guidelines to public agencies in the formulation and introduction of programs and projects related to older persons.
- To establish systems and procedures to evaluate the effectiveness and improve the coordination of programs and projects of public agencies and private entities that address the needs and problems of older persons.
- To encourage the participation of citizens in the development and introduction of projects and programs to assist older persons and to facilitate their communication with public agencies.
- To provide advice, technical assistance, and professional services to public agencies and private institutions that so request it, in order to improve the services provided and to satisfy operating requirements established by laws or regulations.

- To organize and hold lectures, seminars, and workshops, and to carry out studies and research either alone or in coordination with other public and educational agencies and private institutions and any other organization that carries out activities akin to the purposes of this Law, for the development of new points of view, methods, programs, and services, and the training and improvement of the personnel necessary to provide services to the elderly.

  In addition, coordination and collaboration should be established with colleges, universities, and postsecondary educational institutions to design a curriculum and to plan materials and texts in gerontology.
- To promote the establishment of services and, when appropriate, use them as demonstrations or models to be subsequently transferred to public or private organizations such as clinics for preparing for old age and retirement, day care centers with multiple activities, geriatric clinics, and others.
- To compile, analyze, and update statistical data for the planning, coordination, and use of available governmental resources for the introduction and development of a public policy on the elderly that meets current needs.
- To promote knowledge and a better understanding of the specifics of the aging process among the citizenry and the elderly.
- To publicize and orient activities in order to develop positive attitudes among citizens and to keep the elderly actively integrated in the community.
- To orient the elderly as to services, benefits, programs, and activities offered by public agencies and private entities.
- To designate the necessary special committees to carry out the office's functions in collaboration with the Advisory Council.
- To recommend to the Governor and to the Legislative Assembly those measures believed necessary to address the needs and problems of the elderly.

The law also authorizes the development of agreements and contracts with federal agencies and receiving funds from these agencies. Furthermore, it designates the Office as the administrator of funds from Federal Law 89-73 of 1965, known as the "Older Americans Act."

It should be mentioned that, at the same time as policies and infrastructure are being developed to handle the older population in general, a conscience and infrastructure are being created in Puerto Rico to address the affairs and rights of the Puerto Rican woman. An agency for this purpose, currently named the Commission on Women's Affairs, has existed for more than a decade, which, like the Office on Affairs of the Aging, is assigned to and reports directly to the Office of the Governor. This Commission on Women's Affairs last year doubled its budget.

We should point out, however, that in our opinion, priorities for action have been more strongly directed to the younger female population, with emphasis on such aspects as creating children's day care centers, marital abuse, double employment, equal pay for equal work, and legislation that addresses the coadministration of property and sexual harassment. We recognize, nonetheless, that we are rapidly beginning to fight the problems of adult and elderly Puerto Rican women that have been identified by scientific research for more than a decade.

The new Commission on Women's Affairs provides what we consider a propitious opportunity for joint action between the two agencies: I am a member of the Commission and I also direct the Affairs on the Aging. To this end, we have requested that specific time be allotted to explore avenues of cooperation for the benefit of the older female population.

In terms of priorities, one of the areas that most concerns us is the stereotyping of the aging process and the discrimination suffered especially by the female elderly. We attribute this situation, in part, to the association of the aging process with loss, illness, and distress. This emphasis on the negative aspects of aging and on the losses inherent to the process have caused many people to have serious fears about aging and to reject anything that reminds them of its inevitability.

The psychology of aging recognizes that the aging processes, far from being uniform, vary in terms of individuals, social and cultural aspects, sex, and characteristics of the family structure; nevertheless, the popular view is that the process is a single one, which puts pressures on and limits action, especially for the female sex.

By means of a mass education program disseminated through the mass media, we will commit resources and efforts to break such stereotypes.

As part of this effort to break the myths about aging, especially regarding women, we conducted research under the auspices of the Center for Social Research of the University of Puerto Rico, using life histories as our methodology. The first phase of this research project explored needs, processes of adaptation, and crises suffered, as well as fulfillment and self-esteem.

The publication about the lives of these elderly persons, predominantly female, notes that, contrary to common assumptions, these women have made wonderful daily adjustments and possessed commendable skills in managing their lives. These strong Puerto Rican women overcame negative events and social pressures. Most of them enjoyed good mental health, felt reasonably happy, and maintained a certain optimism. These findings agree with studies carried out by other researchers.

As several of the women expressed, they were persons who had been through good times and bad; had learned from both; knew how to handle their stress, tensions, and anger; and had survived physically and emotionally. Interestingly, they tended to depend less on external events for their personal satisfaction. In Eriksonian terms, these admirable women had fully integrated egos and were nowhere near anguish.

This briefly summarized study convinced us even more that widely held stereotypes of what it means to be a middle-aged or elderly woman were not valid. To age is not a tragedy, and we must devote time to communicating that idea.

We must recognize, however, that we also found women whose lives were anguished, distressed, and needy, though they were in a minority. The majority displayed coping skills, could function efficiently, and had active support networks constituted mainly of the immediate family, especially the children.

The previous findings should not make us complacent, because the picture also reflects many needs unmet by public and private services.

In health, which is consistently expressed as a priority for older persons, especially women, there is a disparity between what is perceived as a need and how that need is fulfilled. A reorientation of the health and welfare services, including the mental health aspects, no longer can be postponed. To this end we highlight some urgent points:

- Advisory and mental health services for crisis intervention should be developed, especially for situations of late divorce, empty nest, and death of a spouse or child. The traditional medical approach generally has held sway in this area, often prolonging the crisis into a long depression due to the excessive use of drugs.
- The lack of cohesion in health services and their inability to cover frail elderly people also requires prompt action. To this end, we have held public hearings with the General Health Council, an agency that designs guidelines in this area and advises the Secretary of Health on priority actions. This step has led to a clear understanding of where current gaps are in long range, comprehensive, and continuous services. We are confident that soon we will be able to show the way to transform, if only as a demonstration, this system.

The appropriate functional classification of older persons, where attention is given to preventing dysfunction as much as to health promotion, must be part of this view. By the same token, further clarification of priorities regarding the appropriate handling of diseases and chronic and degenerative conditions also must take place. Diseases that affect a relatively high number of elderly women, such as osteoporosis, senility—

especially Alzheimer's disease—and breast cancer, should be particularly addressed.

Nothing will improve the health of adult and elderly women as much as improving the conditions that lead to a good quality of life. Some of these that rank as high priorities include adequate housing, which prevents unnecessary accidents; strengthening of support networks; nutrition tailored to their health status; education to reduce such habits as alcohol and tobacco use; and providing stimulating work and recreation.

Since I come from an academic background, I want to conclude this presentation by stressing the need for social research that can provide specific data on the status, aspirations, satisfaction with life, and characteristics of the adult and aging woman. Very little is known about such factors as the significance of work and retirement for women, since it is assumed that the process is similar to that of men.

How specific roles in the domestic realm have changed is also largely speculative. Many questions remain about how migration affects the lives of women in general, and of elderly women in particular.

Women have not been a high priority in Puerto Rico, much less older adult and elderly women. Grass-roots organization, though still meager, is growing, and we hope that the voices that echo within the political and social systems will spark actions that will result in well-being, quality services, affirmation, and participation. We assure you that we will continue to devote our efforts and energy toward this goal.

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SOCIOECONOMIC POLICIES AND THE STATUS OF THE OLDER WOMAN IN COSTA RICA

Adelina Brenes Blanco[1]

In developing countries such as Costa Rica, a significant increase in the number of persons over 60 is expected in the decades to come. According to the population census of 1984, 6% of the total population, or 158,144 persons, were 60 and older; 48.5% of this population were men, and 51.5% were women. Some 51.8% live in urban areas and 48.2% in rural. Should these trends continue and if the same conditions persist, it is expected that the percentage of persons 60 and over will increase to about 7.3% of the total population by the year 2000, and 14.1% by 2025 (Dirección General de Estadística y Censos, and CELADE, 1983).

These demographic changes may cause serious problems for older people if measures are not promptly taken to satisfy their economic, psychological, physical, environmental, and health needs.

The main subject to be covered in this work is the inequable treatment of older women and the effects this has on their lifestyle and quality of life. We will briefly illustrate how the inequality is reflected in the pension system with respect to the calculation of the woman's old age pension. We will also show how the claimed benefit to older women of reducing the number of years required before retirement does not in fact favor a significant number of women.

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INEQUALITY OF OLDER WOMEN

From the outset, it should be borne in mind that women in general live in and suffer from a situation of inequality that affects them from the moment of their birth to the end of their lives.

The National Development Plan for 1986–1990 states that policies and programs aimed at women shall seek to overcome economic, legal, and political inequities affecting them, and shall develop cultural and educational activities in order to encourage change in patterns of discrimination under the premises of equality of the sexes and shared responsibility in the home (Ministerio de Planificación Nacional y Política Económica, 1987).

In fact, as a result of the fourth priority established in that plan, a draft law to ensure true equality for women is under discussion in our country. It states that "the Constitution guarantees equality of the sexes in article no. 33" (Ministerio de Cultura, Juventud, y Deportes, 1988). The draft goes on to say that one of the most significant reforms is the inclusion of women in all the roles they have earned, and that it must be recognized that for different reasons discrimination against women exists in many areas of national life.

In its introductory exposition, the draft states, "In the last electoral campaign the subject of women's equality was debated by all the political parties. President Arias spoke forcefully of how an indestructible democracy required the equality of women." It continues: "'Among the inequities that we are going to fight in my government,' President Arias once pointed out, 'are those that affect the woman.' And he added, 'We will do it together because the hearts of Costa Ricans are united in seeking justice as we continue our development. If women contribute differently to the development of the country's democracy, it is that they fully understand that before one can ask, one must give. History teaches us that women's participation increases enormously during precisely the most difficult periods: war, catastrophes, and plagues. In times of prosperity, history ignores their requests.'"

Thus, the draft law establishes the political, social, and economic rights of women and grants them equal protection under law. As a result, it should help to eliminate the discriminatory stereotypes of masculine and feminine roles.

On 2 October 1984, the country ratified the Convention on the Elimination of all Forms of Discrimination against Women that was approved by the United Nations on 18 December 1979. Although this initiative is still being discussed in depth, its supporters expect it to have a very positive influence, especially when statistics demonstrate that women are the ones to suffer most from labor and social discrimination. Industry does not contract women if they are married, and there are salary differentials by sex. These problems reflect the magnitude and complexity of the problem of discrimination against all women, which persists in old age.

The problems encountered by the older woman are some of the same ones that have affected her condition as a female throughout her life, but they become even more acute as she grows older, and especially at very advanced ages. Two factors influencing the life of the elderly that today's young adult and midlife women must face, resolve, and prepare for in order to improve their future quality of life are, first, the increase in size of the elderly age group, and second, their economic and employment situation.

DEMOGRAPHIC CHANGES

Costa Rica has a higher proportion of women over 60 than men of the same age, and their numbers continue to grow with time. The reason for this is that men do not live as long as women.

A decrease in mortality and fertility, among other things, has caused an increase in the longevity of the general population, as measured by life expectancy at birth (75.5 years among women and 72.5 years among men). The disparity is even sharper in the later years. Low female mortality also results in a larger number of women over 60 who are widows. Table 1 shows that older people tend to be married.

ECONOMIC AND LABOR STATUS

The older woman's participation in the work force is not only a form of self-realization; in most cases she urgently needs the income for her own

Table 1. Marital status of people 60 and over, by sex, Costa Rica, 1984.

Marital status	Men (%)	Women (%)
Married	64.9	39.2
Widowed	11.3	32.9
Single	10.4	17.4
Consensual union	8.7	4.2
Separated	3.7	4.9
Divorced	1.0	1.5

Source: Centro Latinoamericano de Desarrollo (CELADE).

or her family's well-being. Table 2 illustrates the employment status of women over 60.

According to the survey on basic needs of the elderly carried out in Costa Rica by the Pan American Health Organization in 1984, more than 70% of those interviewed receive some income on a regular basis. This proportion is much greater overall among men than among women, but with advancing age the proportion of women who have an income increases. This could be due to the larger number of older women at more advanced ages (Table 3).

According to this same study, the personal income of those interviewed can be rated as very small, and decreases significantly with increasing age. Older women have much lower income levels than older men, as can be seen in Table 4.

As can be seen in Table 5, fewer older women receive some type of pension than older men. The noncontributory pensions are the ones that most equally benefit both sexes.

There are no differences by sex in the requirements stipulated in the regulations of the Costa Rican Social Security Fund for contributory pensions. However, there is a difference when the pension is calculated with regard to the right to the family allowance. Men are allowed 10% more for their spouse or companion and 10% for children younger than 25 who are students, whereas the few women who manage to earn the right to

Table 2. Employment status of population 60 years and over, by sex, Costa Rica.

Employment status	Both sexes (%)	Men (%)	Women (%)
Employed	22.4	42.5	3.5
Unemployed	3.5	6.3	0.8
Inactive	74.1	51.2	95.7

Source: PAHO, in press.

Table 3. Percentage of persons interviewed who receive income, by age group and sex, Costa Rica.

Age group	Men	Women
Total	82.9	62.3
60–64 years	88.1	59.2
65–74 years	82.0	59.7
75+ years	79.4	71.2

Source: PAHO, in press.

Table 4. Level of income (in colones) of persons interviewed who receive income, by sex, Costa Rica.

Monthly income (colones)[a]	Men (%)	Women (%)
Less than 1,000	21.2	40.0
1,000 to 3,999	41.4	33.6
4,000 to 9,999	28.7	20.2
10,000 or more	8.7	6.2

Source: PAHO, in press.

[a] Exchange rate as of June 1988 = 76.45 colones per dollar.

Table 5. Type of pension received by persons interviewed, by sex, Costa Rica.

Type of pension	Both sexes (%)	Men (%)	Women (%)
Any type	36.5	45.2	29.8
Old-age	4.4	8.0	1.7
Years of service	6.7	10.0	4.1
Disability	6.0	11.2	2.0
Widowhood	3.2	—	5.7
Non-contributory	16.4	16.5	16.3
Others	—	0.4	0.5

Source: PAHO, in press.

retirement cannot usually choose this benefit because they are either single or widowed, or their husband and children are not counted as dependents.

To help women, it was established that they would have the right to retire upon reaching 55 years of age. The regulation on Disability, Old Age, and Death states in articles 14 and 14 *bis*:

> *Article 14*
>
> The following insured males have the right to retirement with old-age pension: those who have reached 57 years of age and have paid a minimum of 408 monthly premiums, those who are 58 with at least 372 premiums paid, those who are 59 with at least 336 premiums paid, those who are 60 with at least 300 premiums paid, those who are 61 with at least 264 premiums paid, those who are 62 with at least 228 premiums paid, those who are 63 with at least 192 premiums paid, those who are 64 with at least 156 premiums paid, and those who are 65 or older with at least 120 premiums paid.
>
> For each month of the insured male's age after 57 years of age, the 408-month requirement for the pension shall decrease by 3 months, it being in no case less than 120 months.

> *Article 14 (bis)*
> The following insured females have the right to retirement with old-age pension: those who have reached 55 years of age and have paid a minimum of 408 monthly premiums, those who are 56 with at least 396 premiums paid, those who are 57 with at least 384 premiums paid, those who are 58 with at least 372 premiums paid, those who are 59 with at least 336 premiums paid, those who are 60 with at least 300 premiums paid, those who are 61 with at least 264 premiums paid, those who are 62 with at least 228 premiums paid, those who are 63 with at least 192 premiums paid, those who are 64 with at least 156 premiums paid, and those who are 65 or older with at least 120 premiums paid.
>
> For each month of the insured female's age after 55 years of age, the 408-month requirement for the pension shall decrease by 1 month, it being in no case less than 372 premiums. For each month of the insured female's age after 58 years of age, the waiting period of 372 premiums shall decrease by 3 months, it being in no case less than 120 months.
>
> In force since 1-5-84. (Thus revised by the Governing Board in session No. 5798 of 29 February 1984 and published in *La Gaceta* No. 69 of 6 April of the same year.)

However, it has been shown that between 1984 and 1987, only five women retired at 55 years of age. A total of 109 women between 56 and 58 years of age had recourse to this benefit in the same period.

CONCLUSIONS

From the foregoing discussion, it can be concluded that the situation of older women is usually difficult, and that it would be useful to do a study in which the women themselves could express how they feel about the inequities between men and women, and the degree to which these problems affect their economic, occupational, educational, housing, and health conditions, and other important areas in their lives.

The older woman does not find work easily, even though she may need a job and be willing to work. Though the laws, regulations, and mechanisms through which they can obtain benefits do not distinguish between the sexes, in practice such distinctions are made.

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FINAL REPORT OF THE MEETING ON MIDLIFE AND OLDER WOMEN[1]

During the meeting three principal aspects of the problems of midlife and older women were analyzed: their health, social condition, and economic status.

HEALTH

With regard to health, it was pointed out that an increase in the population of persons 50 years of age and older can be seen in all countries of Latin America and the Caribbean, and that higher mortality rates in men leads to a higher proportion of women in older age groups.

Morbidity and mortality records for midlife and older women show a clear predominance of chronic diseases, most commonly the cardiovascular diseases, malignant tumors, diabetes, obesity, osteoarticular diseases, and mental disorders.

It was pointed out that there is only limited data on some of these diseases in older women, especially mental disorders. There is a need for more research that takes a comprehensive look at the health of this group of women and examines the way in which diseases and mental disorders are associated with their lifestyles, as well as with the discrimination and undervaluation they suffer in society.

Aging was recognized to be an ongoing process that begins long before midlife. It is advisable to make this clear to the population as well as to health service providers, so that special preventive care aimed at improving living conditions and raising the probabilities of avoiding illness are initiated during the early stages of life.

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[1] Prepared by Mabel Bianco, Ministry of Health and Social Action, Argentina.

Although health services are available, in some cases they are insufficient. In addition, it was noted that the quality of these health services in many countries of Latin America and the Caribbean is inadequate and the services are inappropriate. There is a need to promote the involvement of older persons and their family members in discussions and examinations of the health services in order to improve these services and adapt them to the real needs of this population.

The health problems of midlife and older women must be viewed in light of social, work-related, cultural, and economic factors in order to better understand them and to be able to establish measures to avoid these problems and/or solve them more appropriately and effectively. It was recognized that certain factors—such as obesity, stress, depression, and others having to do with social adaptation—have a high degree of repercussions and influence on the level of health and the health situation of midlife and older women.

Given the growing need for health services, their frequent use by the population, and the economic crisis affecting most of the countries of Latin America and the Caribbean, it was suggested that it is necessary to seek alternative types of care for midlife and older women that will make it possible to cover this population and to adequately meet its needs.

Recommendations

- Promote and encourage comprehensive health studies and research on midlife and older women, including their mental health and occupational and environmental risks, and investigate new methods for more adequately assessing and treating their health problems.
- Provide training to health service personnel on the problems of older persons, their perspectives, and their needs.
- Disseminate the concepts of chronic disease prevention via the mass media, and encourage the involvement of older persons as the principal promoters of their own health. This effort should also be directed towards younger members of the population so that it will be even more effective.
- Promote organized community participation through nongovernmental organizations (NGOs) interested in health services for the elderly.
- Revise health policies in the countries so that they are adapted to the real needs of the elderly, and avoid excessive medicalization of the services.

SOCIAL CONDITION

In relation to social factors, the meeting pointed out the need to encourage the view of aging as a vital process. It was recognized that the elderly population does not constitute a single homogeneous group, but rather a series of different age groups.

Since old age is devalued in our societies, it was suggested that there is a need to create a more positive perception. For this purpose, it was considered advisable that the elderly maintain sufficiently high levels of social integration to avoid marginality, especially in the case of women, who are more affected by this problem than men.

In the countries of Latin America and the Caribbean, older persons maintain very close relationships with their family members. There has also been an evolution of the traditional family to encompass not only direct family members but also friends and neighbors, who to a great extent serve the needs of the elderly population. There is a need to develop informal support systems that are based on these spontaneously established "family groups" and that are better accepted by the populations of Latin America and the Caribbean. There is also a need to make a dynamic examination of support for this population, since changes in access to education and work, along with changes in family structures for midlife and younger women today, will produce alterations in their situation at more advanced ages that will make other types of support necessary.

Recommendations

- Promote and encourage research on current social conditions in Latin America and the Caribbean and their relationship to aging. It is recommended that these be action-oriented research projects that involve midlife and older persons in research design, data collection, and analysis.
- Promote public policies that allow for alternative support systems through the use of informal mechanisms and the involvement of organized community groups through NGOs.
- Consider the economic support and training given to informal groups and NGOs to be a means of providing services that are more adequate and better accepted by the population and that permit interaction between the government and society.
- Promote the organization of midlife and older women as a means of forming power groups, studying needs, reflecting on findings, and seeking new solutions.

- Give consideration to the sexuality of midlife and older women as a fundamental social aspect of their relationships with others.
- Study the new types of family and social organization that support the needs of the elderly population. Investigate new patterns of household sharing that lead to better development and well-being in this population.

ECONOMIC STATUS

In the discussion of economic factors, consideration was given to the involvement of midlife and older women in the work sector and to the availability of economic resources. Emphasis was placed on the multiple tasks performed by these women in society and to the significant contribution they constitute. More data must be made available on the participation of midlife and older women in the formal and informal employment sectors, since in many cases their involvement in these sectors goes unrecognized and they become "invisible" (an example is domestic workers).

The need for updated legislation that supports the development of social security while eliminating discrimination against women in general and against midlife and older women in particular is fundamental in Latin America and the Caribbean.

Recommendations

- Make more data available on the economic activities of midlife and older women in both the informal and formal sectors. Include data on the primary activities and tasks of women, describing the different types of work that they perform. Promote research on new indicators, including evaluation of income and the economic contribution resulting from the multiple tasks carried out by these women. Also examine the internal and international migration of midlife and older women.
- Promote increased interaction between the producers of statistics and their users, especially those who set policies. Suggest that more data be collected on midlife and older women, and that it be more thoroughly processed, analyzed, published, and disseminated.
- Promote the extension of social security coverage (economic provisions, social and health services) in all countries of the Region, especially those with less well-developed social security systems.

- Promote the development of programs of action, with the involvement of NGOs, to serve this population and make possible the investigation of new modes of caring for the elderly.
- Educate the population in general, especially young people and health workers, concerning the needs and concerns of midlife and older women.
- Promote changes in any legislation that discriminates against women.
- In planning, take into consideration the evolution of cohorts of women by age, and examine the changes that occur in them.
- Create joint networks of governmental and nongovernmental organizations to prevent the social mortality of women that accompanies advanced age.
- Establish organizations of midlife and older women that will give them more power in society.
- Promote women's organizations that will examine and reflect upon women's rights and will constitute power groups for promoting women's equality.

International agencies are urged to:

- Expand the conceptual framework of their publications on the problems of midlife and older women, the services available to them, and the statistics to be developed.
- Promote meetings at which governmental agencies and NGOs can exchange experiences and research.
- Promote and support research projects and studies on the problems and comprehensive situation of midlife and older women through subsidies and/or other economic support.
- Disseminate studies, research, and statistics on the situation of midlife and older women through publications, videotapes, and other media.
- Support a network of investigators, scholars, and organizations that work in both the governmental and nongovernmental sectors on the needs of and services for midlife and older women.
- Prepare a list of persons, groups, and organizations that work in this area, and make this list widely available.

As a result of advances in health care and disease prevention, a larger proportion of the world's population is now surviving to old age. The problems of older women deserve special attention, not only because more women than men survive to old age but also because they reach that vulnerable stage of life having already faced a lifetime of difficulties and discrimination related to their sex. For these reasons, PAHO and the AARP present an in-depth look at the current situation of women at midlife and old age in Latin America and the Caribbean.

The background paper, prepared for the AARP/PAHO Consulting Group Meeting on Midlife and Older Women held in October 1988, comprehensively summarizes the situation in the entire Region of the Americas. It draws a portrait of a group of women diverse in social and cultural background but united by problems inherent to being female and middle-aged or elderly in male-dominated and youth-oriented societies. Other papers presented at the same meeting explore the condition of older women in specific countries from the perspectives of health, social and psychological well-being, and economic status.

Poverty, bad health, and social isolation are the lot of too many older women today, but these conditions are not inevitable. Health policy planners at all levels, community health workers, and any interested individual will gain increased awareness of the problems and insights to solutions from this collection of reports by international experts. ❧

Pan American Health Organization
Pan American Sanitary Bureau
Regional Office of the
World Health Organization

AARP

American Association
of Retired Persons